

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14514

CERTIFICATE OF DEATH

14524

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN IT <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Frederick Banzhoff</u> First Middle Last		4. DATE OF DEATH <u>Oct. 13 1967</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 10 1893</u> Month Day Year
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>2</u> Hours <u></u> Min. <u></u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Brick Co.</u>	
13. BIRTHPLACE (County & State, or foreign country) <u>Washington Co., Maryland</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>George Banzhoff</u>		16. MOTHER'S MAIDEN NAME <u>Annie Poole</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. <u>216-07-1177</u>	
19. INFORMANT <u>Earl Richardson Banzhoff Williamsport Md.</u>		Address	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis Heart Failure</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Obesity Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 weeks</u> <u>15 years</u> <u>40 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholelithiasis - Arteriosclerosis, Hypertension of Lungs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 19 1967</u> to <u>Oct 13 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 13 1967</u> , and that death occurred at <u>1:54 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dalton M. Welty</u>		22b. DATE SIGNED <u>Oct. 14, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dalton M. Welty, M.D.</u>		22d. ADDRESS <u>998 Potomac Avenue, Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 15-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Williamsport Wash. Md.</u>
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 17 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

14515

CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove for the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 Hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH WALKER BARNES		4. DATE OF DEATH Month Oct Day 14 Year 1967	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7 1895
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler maker		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Orange, Orange Co Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William M. Barnes		14. MOTHER'S MAIDEN NAME Elizabeth Patton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W.W.#1		16. SOCIAL SECURITY NO. 705-10-6175	
17. INFORMANT Mrs Bessie Barnes		Address 449 W. Antietam St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Arteriosclerotic coronary artery disease DUE TO (c) Arteriosclerotic coronary artery disease		INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 1954 to Oct. 14, 1967 , that (I) (we) last saw the deceased alive on Oct. 14, 1967 , and that death occurred at Oct. 14, 1967 M, from causes and on the date stated above.			
22a. SIGNATURE Howard N. Weeks		22b. DATE SIGNED 10/16/67	
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M. D.		22d. ADDRESS 580 Northern Avenue Hagerstown, Maryland 21740	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/17/67	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		25a. REC'D BY REGISTRAR Oct 18 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

10012

Division of Investigation

Washington, D.C.

April 10, 1935

MEMORANDUM

Washington County, New York

JOSEPH WATKINS

April 10, 1935

Division of Investigation

Washington, D.C.

Albany, New York

Albany, New York

Albany, New York

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Handwritten signature

April 10, 1935
Albany, New York

Albany, New York
April 10, 1935

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CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 Weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS 1426 Jefferson Blvd.	
3. NAME OF DECEASED (Type or print) George Junior Frederick Bartlett		4. DATE OF DEATH Month October Day 17 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1944
9. AGE (In years last birthday) yrs. 22		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tree Surgery	
11. BIRTHPLACE (County & State, or foreign country) Charles Town, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George F. Bartlett		14. MOTHER'S MAIDEN NAME Mary Fiddler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-46-6131	
17. INFORMANT Mrs Mary F. Bartlett		18. ADDRESS Charles Town, W.Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic heart disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____			INTERVAL BETWEEN ONSET AND DEATH 6 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 20, 1967 , to 17 Oct, 1967 , that (I) (we) last saw the deceased alive on 16 Oct 1967 , and that death occurred at 4:24 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Eldon D Hoachlander		22b. DATE SIGNED 10/11/67	
22c. PHYSICIAN'S NAME (Type) Eldon D Hoachlander		22d. ADDRESS Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 19/67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Maryland
24. FUNERAL DIRECTOR Hagerstown, Md. Andrew K. Coffman Funeral Home Inc.		25a. REC'D BY REGISTRAR DATE OCT 23 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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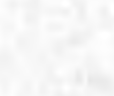
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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2c & d Film #G393 10/20/67 ph

14517

CERTIFICATE OF DEATH

14527

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SanMar Md. c. LENGTH OF STAY IN 1b 12 years		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SanMar Md. Hagerstown d. STREET ADDRESS 1320 Hamilton Blvd. e. IS RESIDENCE ON A FARM? <input type="checkbox"/> ND <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alfred S. Bendell Sr. First Middle Last 4. DATE OF DEATH Oct. 14 1967 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk 10b. KIND OF BUSINESS OR INDUSTRY city gov.		11. BIRTHPLACE (County & State, or foreign country) Albany, N. Y. 12. CITIZEN OF WHAT COUNTRY? Albany, N. Y.	
13. FATHER'S NAME Moses W. Bendell		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 126-01-6363	
17. INFORMANT Alfred S. Bendell, Jr.		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a); (b); and (c).) PART I. DEATH WAS CAUSED BY: 177X IMMEDIATE CAUSE (a) arteriosclerosis DUE TO (b) coronary atherosclerosis DUE TO (c) myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1-4 14	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1, 1967 to Oct. 14, 1967 , that (I) (we) last saw the deceased alive on Oct. 13, 1967 , and that death occurred at 5:15 M, from causes and on the date stated above.			
22a. SIGNATURE G. W. L. E. Van 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED 10/15/67 22d. ADDRESS 1320 Hamilton Blvd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10-16-67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Rowland Funeral Home, ClearSpring, Md.		25a. RECEIVED BY REGISTRAR OCT 17 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14518

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14528

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>1320 Petersville Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eleanor Watkins Bissitt</u>		4. DATE OF DEATH Month Day Year <u>10 20 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-06</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William A. Watkins, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Margaret S. Remsberg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-42-1511</u>	
17. INFORMANT <u>William W. Wenner</u>		Address <u>Brunswick, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary occlusion</u> DUE TO (b) <u>arteriosclerotic coronary artery disease</u> DUE TO (c) <u>disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Howard N. Weeks</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Howard N. Weeks</u>		22. DATE SIGNED <u>10/20/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-24-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Marks Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Petersville Maryland</u>	
24. FUNERAL DIRECTOR <u>Feste Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1901

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[Faint signature]

14519

CERTIFICATE OF DEATH

14529

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN TB 30 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 808 HAMILTON BLVD.		e. STREET ADDRESS 808 HAMILTON BLVD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DAVID First EDGAR Middle BUSEY Last		4. DATE OF DEATH Month OCTOBER Day 29 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/11/1914
9. AGE (In years and birth day) 53 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) INSPECTOR	
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME DAVID E. BUSEY		14. MOTHER'S MAIDEN NAME NELLIE WADDELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 180-01-5416	
17. INFORMANT MRS. BARBARA BUSEY		18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO (b) cardiovascular DUE TO (c) General arteriosclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 18, 1967 to Oct 29, 1967 that (I) (we) last saw the deceased alive on Oct 9, 1967 , and that death occurred at 11 P.M. from causes and on the date stated above.			
22a. SIGNATURE Francisco Rosillo		22b. DATE SIGNED 10/30/67	
22c. PHYSICIAN'S NAME (Type) FRANCISCO ROSILLO		22d. ADDRESS 580 Northern Ave. Hagerstown	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11/1/67	23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown Md.		25a. REC'D BY REGISTRAR NOV 2 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

CERTIFICATE OF DEATH

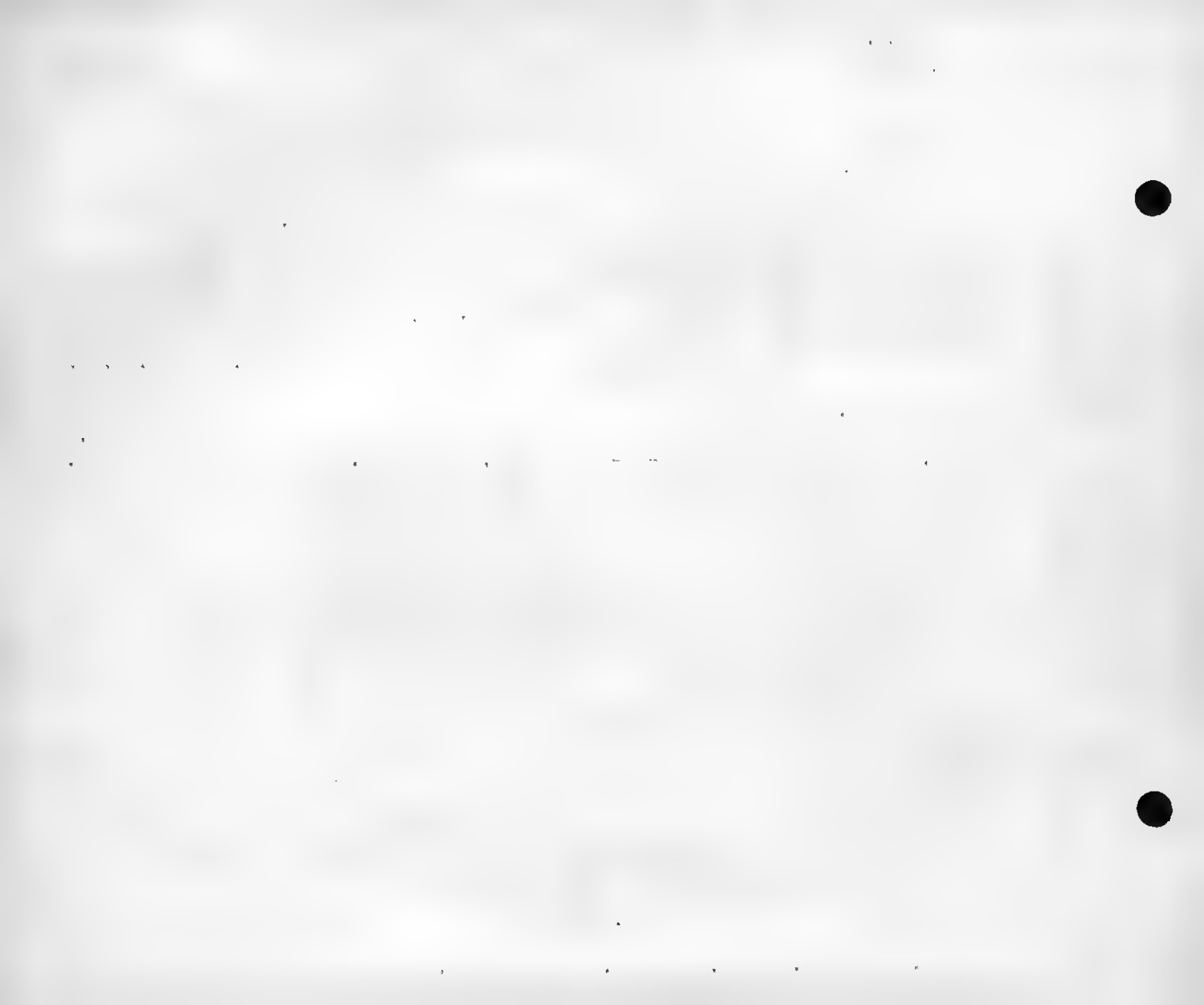
14520

14530

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b Hagerstown		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 717 Sunset Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Morgan Butler		4. DATE OF DEATH Month Day Year October 26, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1901
9. AGE (In years last birthday) 65		10. IF UNDER 1 YEAR Months Days Hours M.n. 10 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Manager		10b. KIND OF BUSINESS OR INDUSTRY Appliance	
11. BIRTHPLACE (County & State, or foreign country) Mc Kees Rocks, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William J. Butler		14. MOTHER'S MAIDEN NAME Kezie Burwith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No. ---		16. SOCIAL SECURITY NO 214-09-8103	
17. INFORMANT Mrs. Imogene L. Butler, 717 Sunset Ave.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary infarction DUE TO (b) Coronary thrombosis DUE TO (c) Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 19, 1966 to Oct 26, 1967 , that (I) (we) last saw the deceased alive on Oct 26, 1967 , and that death occurred at 12:25 PM from causes and on the date stated above			
22a. SIGNATURE L. L. Packer Jr.		22b. DATE SIGNED 10/27/67	
22c. PHYSICIAN'S NAME (Type) L. L. Packer Jr.		22d. ADDRESS 145 W. Washington St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-28-67	
23c. NAME OF CEMETERY OR CREMATORY St. Marks Cemetery		23d. LOCATION (City or Town) (County) (State) Lappans, Maryland	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR OCT 30 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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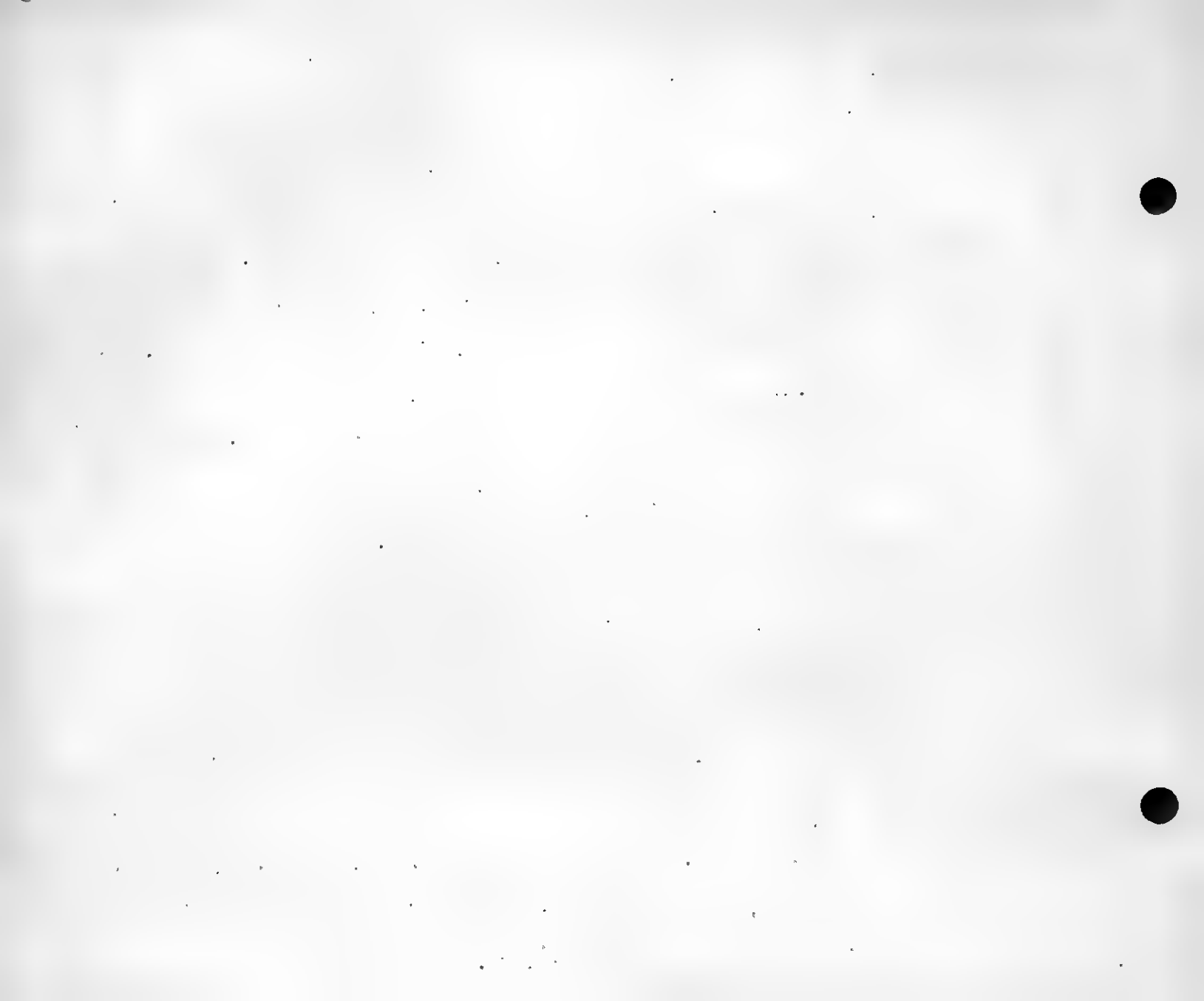
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14531

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3253 Yosemite Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Martin</u> Last <u>Calaman</u>		4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 22, 1892</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Arch brick Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Calaman</u>		14. MOTHER'S MAIDEN NAME <u>Emma Bland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Melvin A. Calaman</u>		3253 Address <u>Yosemite Av. Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>many</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 28, 1966</u> to <u>Oct 2, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 1, 1967</u> and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edson B. Moody</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>Oct. 2, 1967</u>
22c. PHYSICIAN'S NAME (Type) <u>Dr. Edson B. Moody</u>		22d. ADDRESS <u>145 S. Prospect St. Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 5, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Tolson Chapel Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Sharpsburg, Maryland</u>
24. FUNERAL DIRECTOR <u>Albert L. Leaf</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
ADDRESS <u>7 Church St. Williamsport, Md.</u>		DATE <u>OCT 10 1967</u>	



14522

CERTIFICATE OF DEATH

14532

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN TB <u>28 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>153 S. Church St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Minerva Maude Calimer</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>21</u> Year <u>1967</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Feb. 22, 1887</u>		9. AGE (in years last birthday) <u>80</u> yrs	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife & Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newberry's Store</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Waynesboro, R.D. 4 Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>A. Hamilton Snider</u>				14. MOTHER'S MAIDEN NAME <u>Annie E. Stull</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>199-05-8429</u>		17. INFORMANT <u>Howard E. Calimer</u>		Address <u>153 S. Church St. Waynesboro, Pa.</u>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure.</u> DUE TO (b) <u>Cerebral thrombosis and hemorrhage</u> DUE TO (c) <u>Intraarterial surgery for trigeminal neuralgia.</u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertension.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 22, 1967</u> , to <u>Oct. 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct. 21, 1967</u> , and that death occurred at <u>8 p.m.</u> from causes on and the date stated above.							
22a. SIGNATURE <u>A. F. Abdullah</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A. F. Abdullah</u>				22d. ADDRESS <u>132 N. Potomac, Hagerstown Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/23/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Burns Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Waynesboro, Franklin, Pa.</u>	
24. FUNERAL DIRECTOR <u>Walter J. Grose</u>				ADDRESS <u>Waynesboro, Pa.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 24 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u>			



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14523

14533

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>41 Yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. STREET ADDRESS <u>1021 Jefferson Blvd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>Elizabeth</u> Last <u>Carbaugh</u>		4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 28, 1890</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co. Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Hassler</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Underwood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mrs. Herman Leedy 28 Hampton Rd. E.</u>		Address <u>Williamsport, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Edema</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Hypertensive Encephalopathy</u> DUE TO (c) <u>Hypertensive Arteriosclerotic C-V Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 days</u> <u>Yes.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dilated Myocardium</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>30 Nov.</u> , 19 <u>66</u> , to <u>19 Oct.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>19 Oct.</u> 19 <u>67</u> , and that death occurred at <u>10:25 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>20 Oct. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. N. FENDER</u>		22d. ADDRESS <u>218 N. Potomac St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u>		25a. REC'D BY REG. STRAR <u>[Signature]</u>	
Address <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>OCT 23 1967</u>			



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1

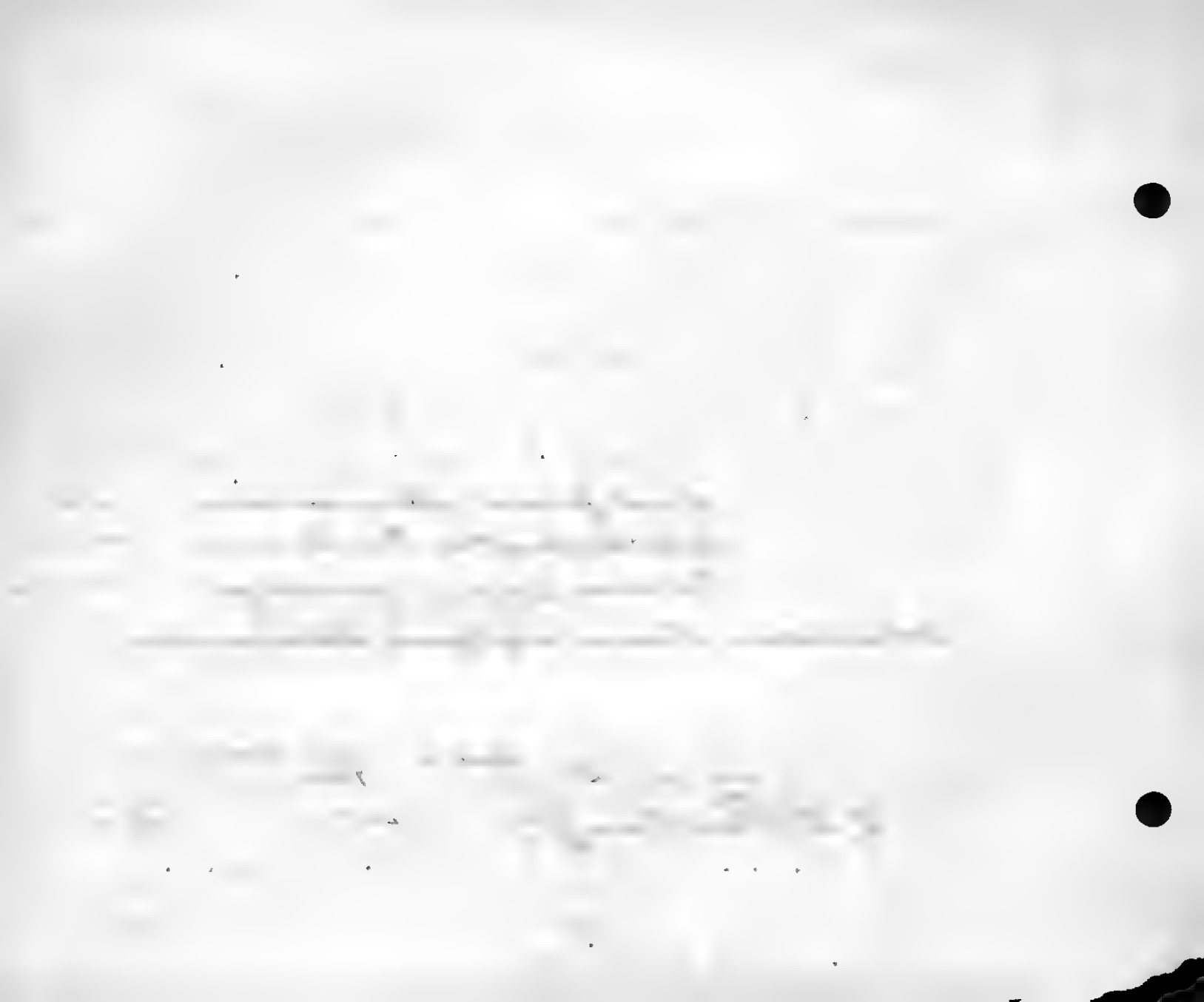
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14524

CERTIFICATE OF DEATH

14534

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 Hr	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 48 Madison Ave	
3 NAME OF DECEASED (Type or print) MATTIE LEE CARTER		4. DATE OF DEATH Month Oct. Day 12 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22 1892
9 AGE (In years last birthday) 75 yrs		10 IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Min.	
11b USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housemother		11c KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State or foreign country) Stanley Page Co Va.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Norman		14 MOTHER'S MAIDEN NAME Alice Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 420-18-2230	
17 INFORMANT Amos Stoneberger		Address 43 Alexander St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right femoral artery embolism DUE TO (b) Arteriosclerosis C V System DUE TO (c) Arteriosclerosis, generalized		INTERVAL BETWEEN ONSET AND DEATH 1 day Unknown	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition, Pulmonary emphysema, diabetic mellitus		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 12, 1967 to Oct 12, 1967 , that (I) (we) last saw the deceased alive on Oct 12, 1967 , and that death occurred at 7:15 PM , from causes and on the date stated above.			
22a SIGNATURE L.L. Parker M.D.		22b DATE SIGNED 10/13/67	
22c. PHYSICIAN'S NAME (Type) Dr. L.L. Parker		22d ADDRESS 145 W. Washington, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 10/16/67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md
24. FUNERAL DIRECTOR Andrew K. Coffman		25a. REC'D BY REG STRAR OCT 16 1967	
25b REG STRAR'S SIGNATURE J. Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14535

14525

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 843 DEWEY AVENUE	
3 NAME OF DECEASED (Type or print) First Middle Last MARY SUSAN CEARFOSS		4. DATE OF DEATH Month Day Year OCTOBER 14 19 67	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 17 1905
9 AGE (in years last birthday) 62 yrs		10 IF UNDER 1 YEAR Months Days Hours Min 10 14 16 16	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY ANTIQUA SHOP	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CNTY MD.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME FRISBY SPICKLER		14. MOTHER'S MAIDEN NAME M. ELLEN SHANK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 218-30-9595	
17. INFORMANT ROBERT K CEARFOSS		18. ADDRESS 843 DEWEY AVENUE HAGERSTOWN MD 21740	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding Gastric ulcer DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO (d) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple Myeloma			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (DOX KOSKOW) attended the deceased from Oct. 5, 1967 to Oct. 14, 1967 , that (I) (We) last saw the deceased alive on Oct. 14, 1967 , and that death occurred at 10:40 PM from causes and on the date stated above.			
22a. SIGNATURE Arturo M. Riego		22b. DATE SIGNED 10/16/67	
22c. PHYSICIAN'S NAME (Type) ARTURO M. RIEGO M. D.		22d. ADDRESS 119 ANTIETAM ST. HAGERSTOWN MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/17/67	23c. NAME OF CEMETERY OR CREMATORY MT. TABOR LUTH CEMETERY	23d. LOCATION (City or Town) (County) (State) RURAL CLEAR SPRING MD.
24. FUNERAL DIRECTOR CHARLES M. ROUZER HAGERSTOWN MARYLAND		25a. REC'D BY REGISTRAR OCT 19 1967 DATE	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14526

CERTIFICATE OF DEATH

14536

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>43 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>924 Preston Road</u>		e. STREET ADDRESS <u>924 Preston Road</u>	
3 NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>NW</u> Last <u>Colley</u>		4 DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 20, 1893</u>
9a. AGE (In years last birthday) <u>74</u> yrs		9b. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sports Writer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Omaha, Nebr.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Colley</u>		14. MOTHER'S MAIDEN NAME <u>Fanny Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>214-09-7686</u>	
17. INFORMANT <u>Mrs. Frank Colley</u>		Address <u>924 Preston Rd. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Atherosclerotic Heart Disease +</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u> <u>25 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adeno Carcinoma Prostate</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 15</u> , 19 <u>67</u> , to <u>Oct 4</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Sept 25</u> 19 <u>67</u> , and that death occurred at <u>6:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward W. Ditto, III</u>		22b. DATE SIGNED <u>10-5-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u>		22d. ADDRESS <u>217 W. Wagh. St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/7/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>		23e. FUNERAL DIRECTOR <u>Wm. C. Harsh</u>	
23f. ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		23g. REGISTRATION NO. <u>0019</u> 19 <u>67</u> 23h. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>208 West 4 th. St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Boy Cullison</u>		4. DATE OF DEATH Month Day Year <u>October 9 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1967</u>
9. AGE (In years last birthday) yrs <u>—</u>		F UNDER 1 YEAR Months Days <u>7</u> IF UNDER 24 HRS. <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Lee Cullison</u>		14. MOTHER'S MAIDEN NAME <u>Sandra Lee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>R.L. Cullison 208 W. 4 th. St. Waynesboro, Penna.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>secondary to Prematurity</u> DUE TO (c) <u>(18 WEEKS gestation)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FORMAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>Hour <u>PM</u> <u>10/10/67</u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.) <u>1</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> , to <u>19</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>A. M. Mandell</u>		22b. DATE SIGNED <u>10/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. M. Mandell, M.D.</u>		22d. ADDRESS <u>301 E. Antietam Street, Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/10/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Host</u>		25a. REC'D BY REGISTRAR <u>ACT 13 1967</u>	
ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judson</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14528

14538

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RJRAT and give nearest town) rural Smithsburg		c. CITY OR TOWN (If outside corporate limits, write RJRAT and give nearest town) rural Smithsburg	
c. LENGTH OF STAY IN TB 3 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD 3		d. STREET ADDRESS RFD 3	
3 NAME OF DECEASED (Type or print) Daniel Eugene Deiffenderfer		4 DATE OF DEATH Month October Day 6 Year 1967	
5 SEX male	6. COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-10-64
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Waynesboro, Pa.	
10b. KIND OF BUSINESS OR INDUSTRY		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Albert J. Deiffenderfer		14 MOTHER'S MAIDEN NAME Dianna Mason	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. none	
17 INFORMANT Albert Deiffenderfer, Smithsburg, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 9160 IMMEDIATE CAUSE (a) Suffocation from smoke in DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) halo-lum. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Months.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Stove Exploded - Trapped on Second Floor of Home.	
20c. TIME OF INJURY Month, Day, Year 9:15 am 10-6-1967		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Smithsburg Wash Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 10-6-67	
ACTUAL SIGNATURE Edward W. Ditto III, MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto III, MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REINTERMENT Burial		23b. DATE THEREOF 9-7-67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR OCT 10 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 15
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14520

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14539

1 PLACE OF DEATH a COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Md. b COUNTY Wash.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg		c LENGTH OF STAY IN 1b 3 years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD 3		e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First William Middle Lee Last Deiffenderfer		4 DATE OF DEATH Month October Day 6 Year 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH 3-21-63
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) 4 yrs.
11 BIRTHPLACE (State or foreign country) Waynesboro, Pa.		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Albert J. Deiffenderfer		14 MOTHER'S MAIDEN NAME Dianna Mason	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) none		16 SOCIAL SECURITY NO none	
17 INFORMANT Albert J. Deiffenderfer		Address Smithsburg, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Suffocation from Smoke in - DUE TO Calculus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH Months
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Stove Exploded Trapped on Second floor of Home	
20c TIME OF INJURY Month, Day Year 9:45 pm 10-6-1967	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home at Ringgold Wash. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III, MD		22. DATE SIGNED 10-6-67	
EXAMINER'S NAME (Type) Edward W. Ditto III, MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 217 W. Wash. St. Hagerstown, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) burial	23b DATE THEREOF 9-7-67	23c NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d LOCAT ON (City or town, county, state) Hagerstown, Md.
24 FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a REC'D BY REG STRAR DATE OCT 10 1967	
		25b REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14530

CERTIFICATE OF DEATH

14540

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL 2 HANCOCK MD.		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle Last DIEHL		4. DATE OF DEATH Month 10. Day 29.. Year 19 67	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2.28.1919
9. AGE (In years last birthday) yrs 48		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON COUNTY MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY BARNHART		14. MOTHER'S MAIDEN NAME BESSIE SEAL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 215 20 9700	
17. INFORMANT MRS SHIRLEY BISHOP		Address RURAL 1 HANCOCK MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Massive Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I(a)) Epilepsy + Alcoholism			INTERVAL BETWEEN ONSET AND DEATH unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-8 , 19 66 , to 10-26 , 19 67 , that (I) (we) last saw the deceased alive on 10-26 , 19 67 ; and that death occurred at 6:30 PM , from causes on and on the date stated above.			
22a. SIGNATURE Charles R Wierer		22b. DATE SIGNED 10-30-67	
22c. PHYSICIAN'S NAME (Type) CHARLES R WIERER		22d. ADDRESS HANCOCK, Md. Wash co	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11.2.67	23c. NAME OF CEMETERY OR CREMATOR PARK HEAD	23d. LOCATION (City or Town) (County) (State) RURAL BIG POOL WASHONG MD
24. FUNERAL DIRECTOR Howard & Gene Hancock md		25a. REC'D BY REGISTRAR DATE NOV 6 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #5, 6, & 7 of Form #5-73 10/13/57 ph
CERTIFICATE OF DEATH

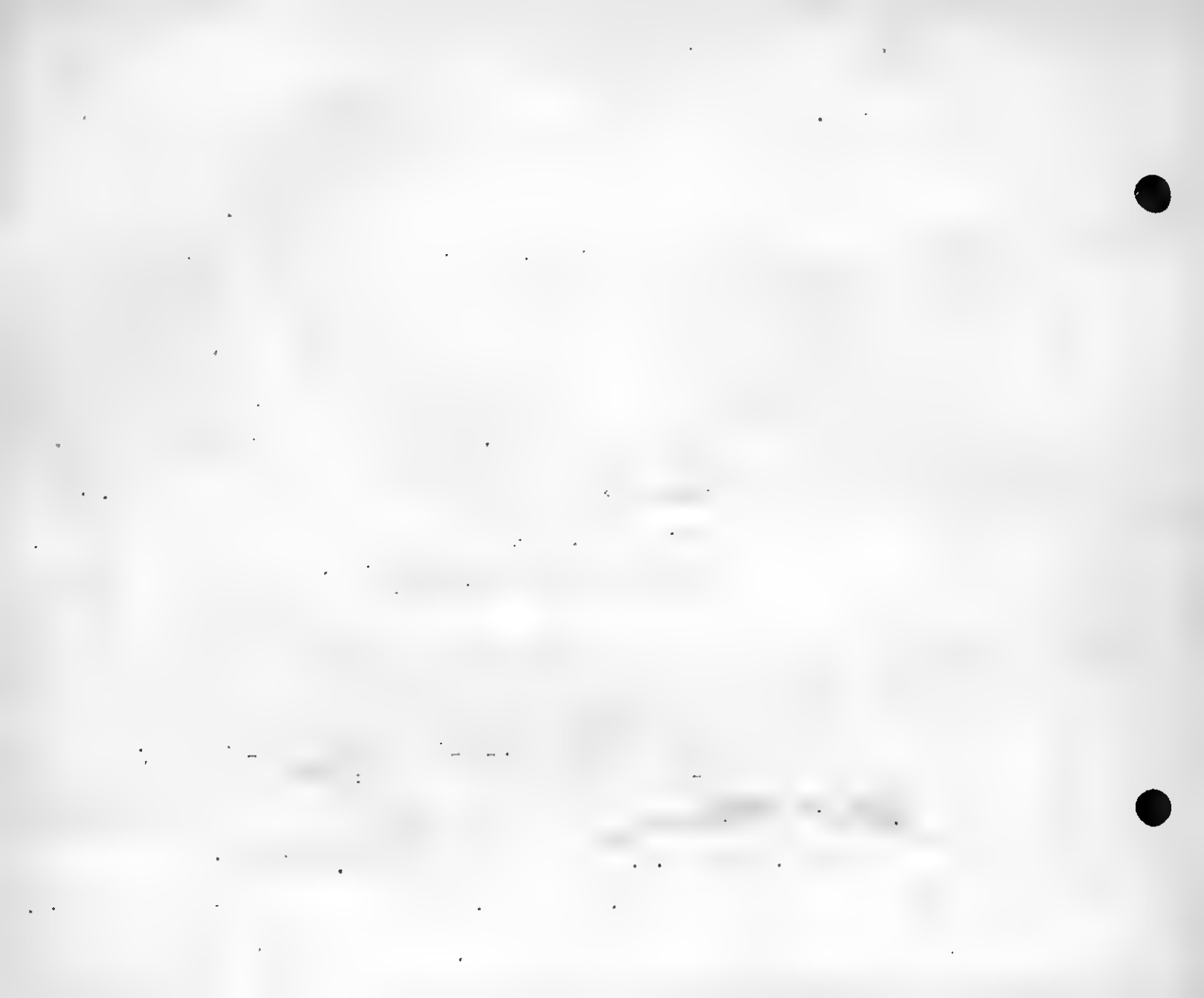
14531

14541

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN It 61 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL				d. STREET ADDRESS 41 W. North Street			
3 NAME OF DECEASED (Type or print) Laura Rachel Dobbins				4. DATE OF DEATH Month 10 Day 5 Year 1967			
5 SEX Female		6. COLOR OR RACE Colored		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 6, 1900	
9 AGE (In years last birthday) 67 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Private family		11. BIRTHPLACE (County & State, or foreign country) Hagerstown Maryland	
12. CITIZEN OF WHAT COUNTRY? USA.							
13. FATHER'S NAME Edward Dangerfield				14. MOTHER'S MAIDEN NAME Caroline White			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 215-14-1011		17. INFORMANT George Dobbins Address 41 W. North St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas 10/5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-9-67 , 19 67 to 10-5 , 19 67 , that (I) (we) last saw the deceased alive on 10-5 19 67 , and that death occurred at 6:45 PM , from causes and on the date stated above.							
22a. SIGNATURE Edwin G. Riley				22b. DATE SIGNED 10-5-67		22c. PHYSICIAN'S NAME (Type) Edwin G. Riley, M.D.	
22d. ADDRESS Western Md. State Hospital Hagerstown, Md.		22e. REC'D BY REGISTRAR John R. Watson Jr.		22f. REGISTRAR'S SIGNATURE Charles Judge		22g. DATE OCT 9 1967	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-10-1967		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR John R. Watson Jr. Hagerstown Md.				25. REC'D BY REGISTRAR John R. Watson Jr.			

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14532 CERTIFICATE OF DEATH 14542									
1. PLACE OF DEATH a. COUNTY Wash. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Hagerstown c. LENGTH OF STAY IN 1b 9 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Avalon Manor					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 700 Raven Wood Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Jeannette Middle Josephine Last Dorsey					4. DATE OF DEATH Month October Day 26 Year 19 67				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-31-1891		9. AGE (In years last birthday) 76 IF UNDER 1 YEAR: Months 7 Days 11 Hours 11 Min. 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Indian Springs Md.			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel Sterling					14. MOTHER'S MAIDEN NAME Josephine Ford				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Paul Dorsey			Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure due to 1551 DUE TO Obstruction, common bile duct due to (b) DUE TO Carcinoma of gall bladder with metastasis to underlying cause last, liver and regional lymph nodes (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none								INTERVAL BETWEEN ONSET AND DEATH 10 days 2 months 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-27-67 , 19 67 , to 10-26 , 19 67 , that (I) (we) last saw the deceased alive on 10-22 , 19 67 , and that death occurred at 6:05 PM from the causes and on the date stated above.									
22a. SIGNATURE John H. Kehne								22b. DATE SIGNED 10-27-67	
22c. PHYSICIAN'S NAME (Type) John H. Kehne, M.D.				22d. ADDRESS 1229 Ravenwood Hgts. Hagerstown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-30-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City, town or county) (State) Hagerstown Md.		
24. FUNERAL DIRECTOR Minnich Funeral Home				ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR OCT 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



14538

CERTIFICATE OF DEATH

14543

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>83 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>R # 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Maudie</u> Middle <u>Glenn</u> Last <u>Eckstine</u>		4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8, 1879</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Springfield, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Glenn</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Colliflower</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>220-54-3830</u>	
17. INFORMANT Address <u>Mrs. Lottie Blickenstaff R # 2 Smithsburg, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Arteriosclerotic C-V Disease</u> DUE TO (c) <u>Arteriosclerosis, Generalized</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Yes</u> <u>Yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11 Sept</u> , 19 <u>63</u> , to <u>Oct 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 4</u> , 19 <u>67</u> , and that death occurred at <u>3:30</u> P.M., from causes and on the date stated above			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>6 Oct 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. N. FENDER</u>		22d. ADDRESS <u>218 N. Potomac St. Hagerstown, Md 21740</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/7/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>OCT 10 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14544

1. PLACE OF DEATH a. COUNTY <u>Washington</u> . MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILLIAMSPORT</u>		c. LENGTH OF STAY IN 1D <u>5 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHAMBERSBURG</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WILLIAMSPORT SANITARIUM</u>				d. STREET ADDRESS <u>974 LINCOLN-WAY EAST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>C.</u> Last <u>ETZBERGER</u>		4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>1967</u>					
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-19-1892</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CHAMBERSBURG-Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL B. MINNICH</u>				14. MOTHER'S MAIDEN NAME <u>MARY-C - LIGHTNER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>F. & M. Trust Co. - Chambersburg Penna.</u> Address <u>20 So. Main St. 17201</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO (b) <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>many years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic asthma & Pulmonary Emphysema</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7-19</u> , 19 <u>65</u> , to <u>Oct 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-29</u> , 19 <u>67</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Edson B. Moody</u>						22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Edson B. Moody.</u>		22d. ADDRESS <u>145 S. Prospect St. Hagerstown, Md.</u>		22e. M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/9/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Chambersburg--Franklin--Penna.</u>			
24. FUNERAL DIRECTOR <u>ROBERT G. SELLERS CHAMBERSBURG PA.</u>				25a. REC'D BY REGISTRAR <u>Oct 11 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

14545

14535

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN TOWN 60 YRS.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 108 CLINTON AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARAH Middle BELLE Last GABRIEL		4. DATE OF DEATH Month OCTOBER Day 1 Year 1967			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/29/1884	9. AGE (In years lost to day) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME LEVI HOCH		14. MOTHER'S MAIDEN NAME ELLEN CRAMER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 219-20-2431		17. INFORMANT MR. HARVIE F. GABRIEL HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) nephrosclerosis DUE TO (b) arteriosclerosis genit DUE TO (c) ant					INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 8/5/67 , 19 to 10/1/67 , 19, that (I) (we) last saw the deceased alive on 10/1/67 , 19, and that death occurred at 9 P M, from causes and on the date stated above.					
22a. SIGNATURE Robert V. H. Campbell M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10/2/67	
22c. PHYSICIAN'S NAME (Type) Robt V. H. Campbell		22d. ADDRESS Hagerstown Md.			
23a. BURIAL, CREMATION, BURIAL	23b. DATE THEREOF 10/4/67	23c. NAME OF CEMETERY OR CREMATORY MT. ZION E.U.B. CHURCH		23d. LOCATION (City or Town) (County) (State) WASHINGTON CO. MD.	
24. FUNERAL DIRECTOR W. J. Normant		25a. REC'D BY REGISTRAR DATE OCT 5 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3-Page-5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film 3363 10/20/67 KK

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-15-16

1 PLACE OF DEATH a COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Penna. b. COUNTY Franklin	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c LENGTH OF STAY IN 1b 2 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chambersburg
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d STREET ADDRESS 421 W. King St.	
3 NAME OF DECEASED (Type or print) Bona Helen Giannoni		4 DATE OF DEATH Month October Day 15 , 19 67	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1959 Jan. 9, 1967
9 AGE (In years last birthday) 8 yrs		10 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Mins 0	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Silver Spring, Md.		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Lino Giannoni		14 MOTHER'S MAIDEN NAME Rose Tillinghast	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO none	
17 INFORMANT Lino Giannoni, Chambersburg, Penna.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Resp. OBSTRUCTION DUE TO (b) Aspiration of vomitus DUE TO (c) Basal skull fracture CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last			
INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) PASSENGER IN CAR (COLLISION)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 1:30 p.m. 13 Oct 1967		20d INJURY OCCURRED While <input type="checkbox"/> of work <input checked="" type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) RT 64 MD. Rock Run Rd		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H. N. WEEKS		22. DATE SIGNED	
EXAMINER'S NAME (Type) H. N. WEEKS		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) 556 Northern Rd Hagerstown Md			
23a BURIAL, CREMATION, or other disposition Burial	23b DATE THEREOF 10-18-67	23c NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d LOCATION (City or Town) (County) (State) Hagerstown, Md.
24 FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a REC'D BY REGISTRAR DATE OCT 17 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14537 CERTIFICATE OF DEATH 14547											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 947 W. Washington St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Elmer First Carl Middle Gibney Last			4. DATE OF DEATH Month October Day 24 , Year 1967								
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-13-91	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) weaver		10b. KIND OF BUSINESS OR INDUSTRY ribbon mfg.		11. BIRTHPLACE (County & State, or foreign country) Washington Co., Md.							
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME George Gibney								
14. MOTHER'S MAIDEN NAME Mary Hose			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no								
16. SOCIAL SECURITY NO. 214-09-1879			17. INFORMANT Edith M. Gibney, Hagerstown, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery block (anaplastic) with metastases (c) 6-12-67 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19								
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								
20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.								
22a. SIGNATURE John J. Donoghue			22b. DATE SIGNED 10-25-67								
22c. PHYSICIAN'S NAME (Type) John J. Donoghue			22d. ADDRESS 580 Northern Ave., Hag., Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF 10-26-67								
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d. LOCATION (City, town or county) (State) Hagerstown, Md.								
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.			25a. REC'D BY REGISTRAR OCT 30 1967								
25b. REGISTRAR'S SIGNATURE J. Charles Judge											



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14539

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14548

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN TB DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS RFD #1, Keedysville, Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Rosa Bell Giff		4 DATE OF DEATH Month October Day 8 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 29, 1908
9. AGE (in years last birthday) 59 yrs		F UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11 BIRTHPLACE (State or foreign country) Samples Manor, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Daniel Behan Hanes		14. MOTHER'S MAIDEN NAME Rosa Bell Mills	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16 SOC. SEC. NO. 220-10-5832	
17 INFORMANT Mr. Walter S. Giff		RFD #1, Keedysville, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. 4201 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Several years		INTERVAL BETWEEN ONSET AND DEATH Few minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. E. W. Ditto, Jr.		22 DATE SIGNED 10-9-67	
EXAMINER'S NAME (Type) D. E. W. Ditto, Jr.		Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/12/67	23c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery	23d. LOCATION (City or town) (County) (State) Samples Manor, Md.
24 FUNERAL DIRECTOR F. Donald Zuckler		25a. PLACE OF REGISTRATION Harpers Ferry, W. Va.	
25b. DATE OCT 13 1967		25c. SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14539

CERTIFICATE OF DEATH

1-15-19

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 16 Mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Friendship Manor Nursing Home				d. STREET ADDRESS 869 Mulberry Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH AMELIA GILBERT				4. DATE OF DEATH Month Day Year Oct 9 1967 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 7 1883		9. AGE (in years last birthday) 84 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William E. Householder				14. MOTHER'S MAIDEN NAME Susan Shugart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 230-05-6167		17. INFORMANT Address Mrs Hilda Long 869 Mulberry Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Atherosclerotic Heart Dis DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 3 hours 8 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carotid Sinus Syndrome						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 11		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5-24 , 19 66 to 10-9 , 19 67 , that (I) (we) last saw the deceased alive on 10-9 , 19 67 , and that death occurred at 9:22 M, from causes and on the date stated above.							
22a. SIGNATURE Robert P. Conrad M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED 10-10-67	
22c. PHYSICIAN'S NAME (Type) Robert P. Conrad				22d. ADDRESS 137 W. Wash Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/11/67		23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Waynesboro Pa Franklin Co	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR OCT 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14540

14550

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown RD #3</u>		c. LENGTH OF STAY IN lb <u>15 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. James College Road</u>		d. STREET ADDRESS <u>St. James College Road</u>	
3. NAME OF DECEASED (Type or print) <u>Rolla A. Griffith</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1 1906</u>
9. AGE (In years last birthday) yrs <u>1</u>		10. IF UNDER 1 YEAR Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>aircraft</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>aircraft</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rolla A. Griffith</u>		14. MOTHER'S MAIDEN NAME <u>Mary Etta Myers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>219-14-7719</u>	
17. INFORMANT <u>Mrs. Martha Sherie Griffith</u>		Address <u>Hagerstown, Md. RD #3</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant carcinoma with generalized metastases</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>23 October 1967</u> to <u>24 October 1967</u> that (I) (we) last saw the deceased alive on <u>24 October 1967</u> , and that death occurred at <u>5:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John R. Marsh</u> M.D.		22b. DATE SIGNED <u>10/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. John R. Marsh</u>		22d. ADDRESS <u>247 N. Potomac St. Hagerstown</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 28-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Sharpsburg Wash. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Albert L. Leaf</u>		ADDRESS <u>Williamsport, Maryland</u>	
25a. REC'D BY REGISTRAR DATE <u>OCT 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14551

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 9 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 112 SOUTH PROSPECT STREET		d. STREET ADDRESS 112 SOUTH PROSPECT STREET	
3 NAME OF DECEASED (Type or print) EUGENE HARRISON GROSS		4 DATE OF DEATH Month Day Year OCTOBER 11, 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 6, 1889
9. AGE (In years last birthday) yrs 78		IF UNDER 1 YEAR Months Days Hours Min 1967	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TELEGRAPH OPER. B&O RAILROAD		11 BIRTHPLACE (County & State, or foreign country) PAW PAW, WEST VIRGINIA	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME ALEXANDER GROSS	
14 MOTHER'S MAIDEN NAME NETTIE ZEILER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO *****	
16 SOCIAL SECURITY NO 705-05-8035		17. INFORMANT MRS. EUGENIA G. KNOTT, HAGERSTOWN, MARYLAND.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 42.0 Anteroseptal heart disease & aortic stenosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 14 yrs -	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (the hospital) attended the deceased from 4-30, 1952 , to 10-11, 1967 , that (I) (we) last saw the deceased alive on 9-18 1967 , and that death occurred at 3:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE John H. Hornbaker		22b. DATE SIGNED 10/12/67	
22c. PHYSICIAN'S NAME (Type) JOHN H. HORNBAKER, M.D.		22d. ADDRESS 154 W. WASHINGTON ST. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE THEREOF 10/12/67	23c. NAME OF CEMETERY OR CREMATORY ST. MARYS BURIAL PARK	23d. LOCATION (City or Town) (County) (State) CUMBERLAND, ALLEGANY CO. MD.
24 FUNERAL DIRECTOR CHARLES M. BOUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR OCT 16 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
20 M 11 88

14542

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14542

1 PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 1, Clear Spring c. LENGTH OF STAY (If in hospital, give street address) 30 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Residence		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring d. STREET ADDRESS Route 1 • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Lloyd # Hastings		4 DATE OF DEATH Month Oct. Day 17 Year 19 67	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Church	9 AGE (n years last birthday) 78 yrs. IF UNDER 1 YEAR Months Days Hours Min 12 CITIZEN OF WHAT COUNTRY? U.S.A.
11. BIRTHPLACE (County & State, or foreign country) Mooresville, Md.		13. FATHER'S NAME Thomas Hastings	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None	
16 SOCIAL SECURITY NO 212-03-4186		17. INFORMANT Howard Western Address Route 1, Clear Spring Md.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate with metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. XXXX (b) Arteriosclerotic Heart Disease DUE TO (c) ??		INTERVAL BETWEEN ONSET AND DEATH 5 years ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Duodenal ulcer with bleeding		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 20 , 19 62 , to Oct. 17 , 19 67 , that (I) (we) last saw the deceased alive on July 5 , 19 67 , and that death occurred at 5:45 A.M. from causes and on the date stated above			
22a. SIGNATURE Archie Robert Cohen, M.D.		22b. DATE SIGNED 10/17/67	
22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.		22d. ADDRESS Clear Spring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/67	
23c. NAME OF CEMETERY OR CREMATORY Blairs Valley Cemetery		23d. LOCATION (City or Town) (County) (State) Blairs Valley Md.	
24. FUNERAL DIRECTOR Rowland Funeral Home		25a. REC'D BY REGISTRAR Oct 20 1967	
25b. REGISTRAR'S SIGNATURE OTL...			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14548

14553

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DCA WASHINGTON County Hospital				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAVETOWN d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arthur Middle LEE Last Helsley jr				4. DATE OF DEATH Month OCT Day 14 Year 1967			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4 1936	
9. AGE (In years last birthday) 31 yrs.		10. IF UNDER 1 YEAR Months 31 Days 14 Hours 1967		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic				10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Arthur Lee Helsley				14. MOTHER'S MAIDEN NAME ARLENE Kirby			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES Korean				16. SOCIAL SECURITY NO.		17. INFORMANT Fay W Helsley Address CAVETOWN Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Section Rob fatal abdominal hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) trauma DUE TO (c) patient						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Motorcycle struck while riding			
20c. TIME OF INJURY Month, Day, Year Hour 7:30 p.m. 10-14 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Public Highway		20f. (City or town) (County) (State) Smithsburg Woodstock Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE E.W. Ditto Jr.				M.D. 22. DATE SIGNED 10/15/67			
EXAMINER'S NAME (Type) E. W. DITTO JR. M. D.				215 W WASHINGTON STREET, HAGERSTOWN MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 10/15/67		23c. NAME OF CEMETERY OR CREMATORY MASSANUTTEN Cemetery		23d. LOCATION (City, town or county) (State) Woodstock Va.	
24. FUNERAL DIRECTOR CHARLES M ROUZER HAGERSTOWN MARYLAND				25a. REC'D BY REGISTRAR ACT 19 1967 25b. REGISTRAR'S SIGNATURE O'Connell Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>126 Alexander St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bernard Boyle Henesy</u>		4. DATE OF DEATH Month Day Year <u>October 30 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1904</u>
9. AGE (In years last birthday) yrs. <u>63</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Organ Mfg.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jeremiah Henesy</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Jane Tedrick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NE</u>		16 SOCIAL SECURITY NO. <u>214-09-2943</u>	
17. INFORMANT <u>Mrs. B.B. Henesy</u>		Address <u>126 Alexander St. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypotension - regional M&B</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6-8 hrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 7</u> , 19 <u>62</u> , to <u>Oct 30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 30</u> 19 <u>67</u> , and that death occurred at <u>4:30</u> M., from causes and on the date stated above.			
22a SIGNATURE <u>Edward W. Ditto, III</u> M.D.		22b DATE SIGNED <u>11-1-67</u>	
22c PHYSICIAN'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u>		22d ADDRESS <u>217 W. Washington Street Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/2/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Hunt</u> ADDRESS <u>Hagerstown, Md.</u>		25a REC'D BY REGISTRAR DATE <u>NOV 6 1967</u>	
Rest Haven Funeral Chapel		25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14555

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 8 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George John Hines		4. DATE OF DEATH Month October , Day 19 , Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1897
9. AGE (in years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 6 Days 1 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State, or foreign country) Locust Grove, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David Hines		14. MOTHER'S MAIDEN NAME Florence Stine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 705-07-7750	
17. INFORMANT Mrs. Clark Harwood, Rohrerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 7 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC LUNG DISEASE, HYPERTENSIVE CARDIOVASCULAR DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/11, 1967 to 10/19, 1967 that (I) (we) last saw the deceased alive on 10/19, 1967 , and that death occurred 11:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE R. Amarillo M.D.		22b. DATE SIGNED 10/20/67	
22c. PHYSICIAN'S NAME (Type) R. Amarillo M.D.		22d. ADDRESS Sharpsburg Md	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-22-67	
23c. NAME OF CEMETERY OR CREMATORY Rohrerstown Cemetery		23d. LOCATION (City or Town) (County) (State) Rohrerstown, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR ACT 23 1967	
25b. REGISTRAR'S SIGNATURE William Judge			

14545

CERTIFICATE OF DEATH

14556

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARLOCK CONVALESCENT HOME		d. STREET ADDRESS 92 WEST WASHINGTON STREET	
3 NAME OF DECEASED (Type or print) First WILMER Middle EARL Last HOOVER		4 DATE OF DEATH Month OCTOBER Day 13 Year 1967	
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH JULY 30, 1905
9 AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST HELPER		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
11 BIRTHPLACE (County & State, or foreign country) WASHINGTON CO. MARYLAND.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SILAS M. HOOVER		14. MOTHER'S MAIDEN NAME NANNIE K. SOUDERS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO ***		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. ELLEN F. FORSON, BARRINGTON, N.J.		Address 217 ALBERTSON AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral lobar pneumonia DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 6-8 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Multiple sclerosis. Prostate hypertrophy, Benign			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 6-8 , 19 66 , to 10-13 , 19 67 , that (I) (we) last saw the deceased alive on 10-6- 19 62 , and that death occurred at 5:45 M, from causes and on the date stated above.			
22a. SIGNATURE Edward W. Ditto, III		22b. DATE SIGNED 10/14/67	
22c. PHYSICIAN'S NAME (Type) EDWARD W. DITTO, III, M.D.		22d. ADDRESS 217 W. WASHINGTON ST. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/16/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	23d. LOCATION (City or town) (County) (State) HAGERSTOWN, WASH. CO. MD.
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR OCT 19 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14547

14557

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages (pages 1 and 2) and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 2 Yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Coffman Home for the Aging		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 514 Washington Square e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) SUSAN ELIZABETH HOUSE First Middle Last		4 DATE OF DEATH Oct 27 1967 Month Day Year	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1 1873 9 AGE (In years last birthday) 94 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11 BIRTHPLACE (County & State, or foreign country) Burkettsville Fred Co USA
13. FATHER'S NAME Albert Bagent		14. MOTHER'S MAIDEN NAME Elizabeth (No Record)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO none	
17. INFORMANT Mrs Ruth Hook		Address 31 W. Washington St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis due to arteriosclerosis DUE TO (b) Hagerstown Md. DUE TO (c) Indefinite Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) Arteriosclerotic heart disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from October 23, 1967 , to Oct. 27, 1967 , that (1) (we) last saw the deceased alive on Oct. 23 , 19 67 , and that death occurred at 4 P. M. , from causes and on the date stated above			
22a. SIGNATURE <i>B. B. Kneisley</i>		22b. DATE SIGNED 10/28/67	
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22d. ADDRESS 148 West Washington Street Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/30/67	23c. NAME OF CEMETERY OR CREMATORY Funkstown Cemetery	23d. LOCATION (City or Town) (County) (State) Funkstown Wash Con Md
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		25a. RECD BY REGISTRAR OCT 31 1967	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>

14548

14558

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (circled) pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>7 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>709 Marshall St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Oda</u> Middle <u>Christina</u> Last <u>Hughes</u>				4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 16, 1905</u>		9. AGE (In years last birthday) <u>62</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>		11. BIRTHPLACE (County & State or foreign country) <u>Ridgeley, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Carson Harper</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Starks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>212-24-1864</u>		17. INFORMANT Address <u>Mr. J. M. Hughes 709 Marshall St. Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of gallbladder</u> DUE TO (b) <u>with metastasis to liver</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2/18/66</u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>10/1/67</u> , 19 <u> </u> , and that death occurred at <u>10:25 AM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>Robert V. H. Campbell</u> M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>10/2/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert V. H. Campbell</u>		22d. ADDRESS <u>Hagerstown</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>			
24. FUNERAL DIRECTOR <u>Wm. G. Woot</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

14559

14549

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Washington</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Hagerstown</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>937 Oak Hill Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>George Selden Humphrey</u>		4. DATE OF DEATH Month <u>October</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug. 11, 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vice President</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electric Power Co.</u>	9 AGE (In years last birthday) <u>81</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>Bellville, W. Va.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Edwin Humphrey</u>		14. MOTHER'S MAIDEN NAME <u>Clara E. Stevenson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-5300</u>	
17. INFORMANT <u>Geo. N. Humphrey</u>		Address <u>42 High St. Hingham, Mass.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1951</u> to <u>Oct. 27, 1967</u> that (I) (we) last saw the deceased alive on <u>Oct. 27, 1967</u> and that death occurred at <u>6:45 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Lloyd A. Hoffman</u> M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b DATE SIGNED <u>10/28/67</u>
22c PHYSICIAN NAME (Type) <u>Lloyd A. Hoffman</u>		22d ADDRESS <u>214 N. Potomac St. Hagerstown</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>10/31/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u>		25a REC'D BY REG. SEAR <u>Oct 31 1967</u>	
Rest Haven Funeral Chapel Hagerstown, Md.		25b REGISTRAR'S SIGNATURE <u>John Jones</u>	



FOR STATE HEALTH DEPT

This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14550

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14560

1 PLACE OF DEATH a COUNTY WASH. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Md. b COUNTY Wash.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c LENGTH OF STAY IN lb Hagerstown	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) New York Iron Works		e STREET ADDRESS 833 Maryland Ave.	
3 NAME OF DECEASED (Type or print) Richard Franklin Johnson		4 DATE OF DEATH Month October Day 17 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years and birthday) May 5, 1943 24 yrs.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b KIND OF BUSINESS OR INDUSTRY Iron Works	
11 BIRTHPLACE (State or foreign country) Clear Spring Md.		12 CITIZEN OF WHAT COUNTRY? Md.	
13. FATHER'S NAME Thomas E. Johnson		14. MOTHER'S MAIDEN NAME Evelyn Mullin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 217-42-9455	
17. INFORMANT Mrs. Elizabeth Johnson		Address Hagerstown Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed skull DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH sudden
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Industrial accident-steel frame fell on victim			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Industrial accident-steel frame fell on victim	
20c TIME OF INJURY Month, Day, Year Hour a.m. 10:55xx 10/17/67		20d INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Factory
20f (City or town) Hagerstown, Wash., Md.		(County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Howard N. Weeks</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Howard N. Weeks, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, or other disposition (Specify) Burial		23b DATE THEREOF 10-20-67	
23c NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d LOCATION (City or Town) (County) (State) Hagerstown Md.	
24 FUNERAL DIRECTOR Minnich Funeral Home		ADDRESS Hagerstown Md.	
25a REC'D BY REGISTRAR DCT 20 1967		25b REGISTRAR'S SIGNATURE <i>Charles J. [illegible]</i>	

10/18/67
22. DATE SIGNED

580 Northern Ave.
Hagerstown, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14561			
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro				c. LENGTH OF STAY IN 1b 80 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rfd. 2						d. STREET ADDRESS Rfd. 2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Vinton Callie Jones						4. DATE OF DEATH Month Day Year October 18, 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, 1881		9. AGE (In years last birthday) yrs 86		IF UNDER 1 YEAR Months Days Hours Min. 7 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor				10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lewis Jones						14. MOTHER'S MAIDEN NAME Mary Kauffman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.				16. SOCIAL SECURITY NO. 217-32-5734		17. INFORMANT Address Mrs. Frances Jones, Rfd. 2, Boonsboro, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) Atherosclerotic cardiac DUE TO (b) vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) INTERVAL BETWEEN ONSET AND DEATH 5 yrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1967 , to Oct 18, 1967 , that (I) (we) last saw the deceased alive on Oct 13, 1967 , and that death occurred at 11 A M, from causes and on the date stated above.											
22a. SIGNATURE G. W. Hedden						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Oct 18, 1967			
22c. PHYSICIAN'S NAME (Type) G. W. Hedden						22d. ADDRESS Boonsboro, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10- 20- 67		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery				23d. LOCATION (City or town) (County) (State) Boonsboro, Maryland			
24. FUNERAL DIRECTOR ADDRESS John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.						25a. REC'D BY REGISTRAR Oct 23 1967		25b. REGISTRAR'S SIGNATURE McClendon Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

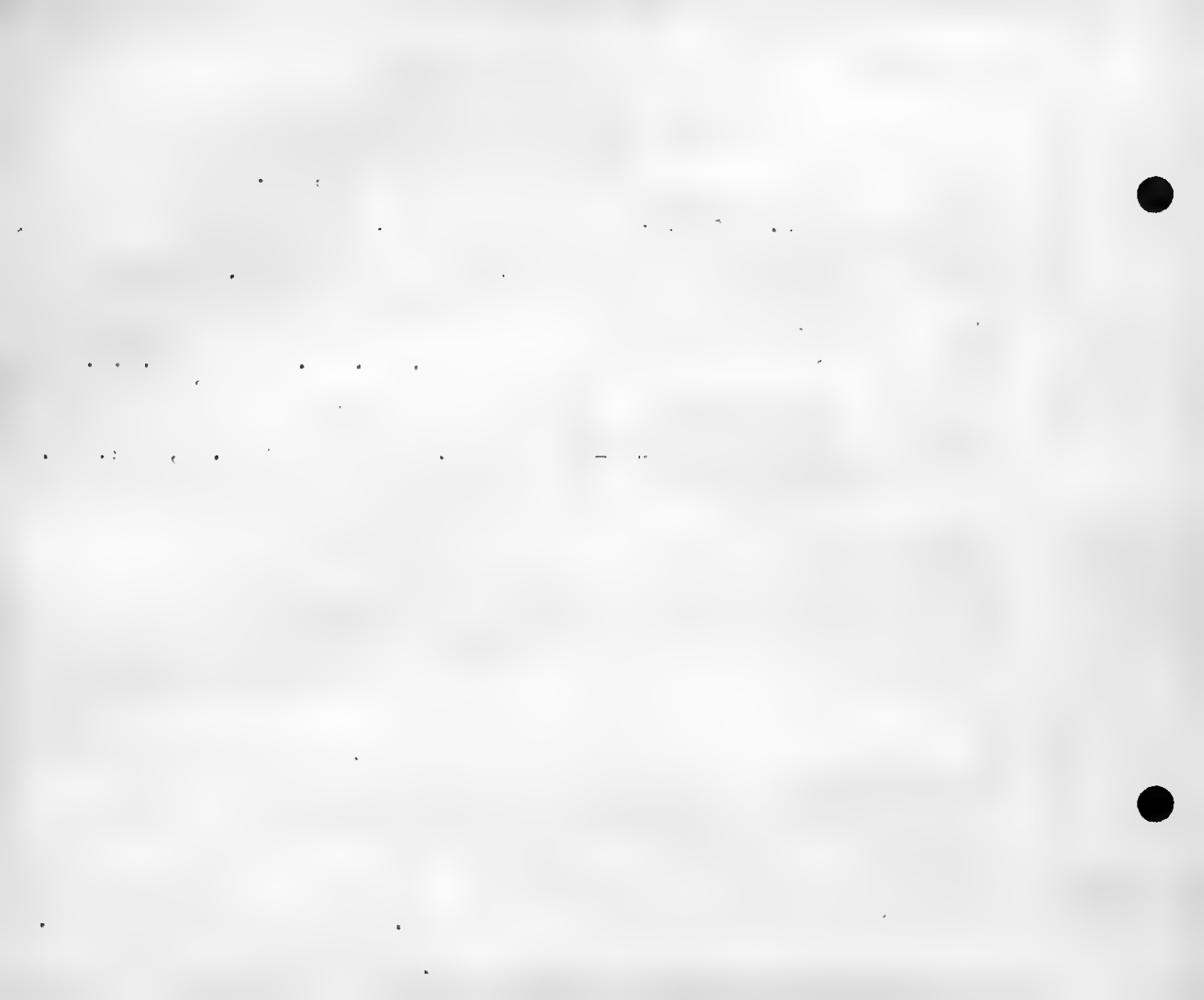
14552

CERTIFICATE OF DEATH

14562

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital				d. STREET ADDRESS Route 4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Lester Kayser				4. DATE OF DEATH Month Oct. Day 20 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/16/99		9. AGE (n years last birthday) 67 yrs	10. IF UNDER 1 YEAR Months 20 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock dealer		10b. KIND OF BUSINESS OR INDUSTRY Animal		11. BIRTHPLACE (County & State, or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Shields Kayser				14. MOTHER'S MAIDEN NAME Bessie Irvine			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-16-0347		17. INFORMANT Mrs Gladys Kayser Address Rd. 4, Hag. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of left middle cerebral artery DUE TO (b) Cerebral atherosclerosis DUE TO (c) atherosclerosis, general							INTERVAL BETWEEN ONSET AND DEATH 1 week unk unk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute subacute heart disease with actual fibrillation; Chronic bronchitis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) no		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 13 October, 1967 , to 20 Oct 1967 , that (I) (we) last saw the deceased alive on 20 October 1967 , and that death occurred at 10:30 PM , from causes and on the date stated above.							
22a. SIGNATURE Clovism Snyder				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 21 October 67	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/23/67		23c. NAME OF CEMETERY OR CREMATORY Blairs Valley Cem.		23d. LOCATION (City or Town) (County) (State) Clear Spring Md.	
24. FUNERAL DIRECTOR Rowland Funeral Home				25a. REC'D BY REGISTRAR DATE OCT 25 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



FOR STATE
HEALTH/DEPT.

14553

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14563

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY WASHINGTON	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c LENGTH OF STAY IN TB 8 YRS.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 49 FAIRGROUND AVE.		e STREET ADDRESS 49 FAIRGROUND AVE.	
3 NAME OF DECEASED (Type or print) HARRY OWENS KING		4 DATE OF DEATH OCTOBER 5 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/25/1888 9 AGE (In years lost birthday) 79 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MINER		10b KIND OF BUSINESS OR INDUSTRY SOFT COAL MINE	
11 BIRTHPLACE (State or foreign country) PENNSYLVANIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME JOHN S. KING		14 MOTHER'S MAIDEN NAME JENNIE JACOBS	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO. 209-09-1319	
17 INFORMANT MRS. NANCY P. KING		18 ADDRESS HAGERSTOWN MD.	
18b CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Atherosclerotic Heart Disease c) Arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH 15 yrs 25 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostate hypertrophy, Benign			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) 217 W. Wash. St. Hagerstown, Md.	
23a BURIAL CREMATION, BURIAL	23b DATE THEREOF 10/7/67	23c NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEM. PARK	23d LOCATION (City or town) (County) (State) HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR W.F. Norment Funeral Home		25a REC'D BY REGISTRAR Charles Judge	
ADDRESS Hagerstown Md.		25b REGISTRAR'S SIGNATURE Charles Judge	
		DATE OCT 10 1967	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, forwarding the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH Washington COUNTY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland STATE Frederick COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c LENGTH OF STAY IN 1b 4 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital		d STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Helen Louise Kline		4 DATE OF DEATH Month Day Year Oct 31 1967	
5 SEX Female	6 COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 12, 1922
9. AGE (in years last birthday) 44 yrs		10. UNDER 24 HRS Months Days Hours Min	
10a USUA. OCCUPATION (Give kind of work done during most of work age, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Clarence Weaver		14 MOTHER'S MAIDEN NAME Anna Metz	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17. INFORMANT Raymond M. Kline, Route 1, Smithsburg		Address	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) massive cerebral hemorrhage DUE TO (b) Cerebral Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 8945		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Aug 1960, to Oct 31, 1967, that (1) (we) lost saw the deceased alive on Oct 31, 1967, and that death occurred at 4:01 M, from causes and on the date stated above			
22a SIGNATURE M.E. Byrkit		22b DATE SIGNED Nov 2, 1967	
22c PHYSICIAN'S NAME (Type) M.E. Byrkit		22d ADDRESS Williamsport Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Nov. 3, 1967	
23c NAME OF CEMETERY OR CREMATORY U.B. Cemetery		23d LOCATION (City or town) (County) (State) Wolfsville Fred. Md.	
24. FUNERAL DIRECTOR Gladhill Company		ADDRESS Middletown, Md.	
25a REC'D BY REG STRAR DATE NOV 6 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #1d Film #334 11/6/67 ph

CERTIFICATE OF DEATH

14555

14565

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		d. STREET ADDRESS 22 West Church St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Rose Middle Mae Last Lamp		4 DATE OF DEATH Month Oct Day 26 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 23 1898
9 AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Wash. County		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel H. Fowler		14 MOTHER'S MAIDEN NAME Rosie E. King	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT Alvey J. Lamp		Address 22 W. Church St. Wmst.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hours 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS A JTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-8, 1962 , to 10-26, 1967 , that (I) (we) lost the deceased alive on 10-26-1967 , and that death occurred at 3 P.M. , from causes and on the date stated above.			
22a. SIGNATURE John H. Stornaker M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) JOHN H. STORNAKER		22b DATE SIGNED 10-27-67	
22d ADDRESS 154 W. Washington St Hagerstown - Md			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 10-30-67	
23c NAME OF CEMETERY OR CREMATORIUM Greenlawn		23d LOCATION (City or Town) (County) (State) Williamsport Wash. Md.	
24. FUNERAL DIRECTOR Howard F. George		19 ADDRESS West Potomac St	
25a REC'D BY REGISTRAR NOV 1 1967		25b REGISTRAR'S SIGNATURE J. Charles Judge	

CERTIFICATE OF DEATH

14566

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 1 1/2 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS Reid	
3. NAME OF DECEASED (Type or print) ALMA MARGUERITE LEHMAN		4. DATE OF DEATH October 2 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10 1926
9. AGE (In years last birthday) 41 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Cascade Wash Co Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Ernest C. Larrabee Sr		14. MOTHER'S MAIDEN NAME Viola Wastler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-22-1598	
17. INFORMANT Leater H. Lehman Jr		Address Hagerstown R # 6	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of chest DUE TO (b) Carcinoma of breast DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 9 months 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 Jan , 19 67 , to 2 Oct , 19 67 , that (I) (we) last saw the deceased alive on 2 Oct , 19 67 , and that death occurred at 7:42 M , from causes and on the date stated above			
22a. SIGNATURE Elder J. Hoachler		22b. DATE SIGNED 10/3/67	
22c. PHYSICIAN'S NAME (Type) Elder J. Hoachler		22d. ADDRESS Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/5/67	
23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Waynesboro Franklin Co Pa.	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		25a. REC'D BY REGISTRAR OCT 9 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



14567

14557

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 week & 1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>R.F.D.#2</u>	
3. NAME OF DECEASED (Type or print) <u>Delores Marie Little</u>		4. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 31, 1923</u>
9. AGE (In years last birthday) yrs. <u>44</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Prince Georges, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Rawlings, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Mary Boswell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>577-24-6044</u>	
17. INFORMANT <u>Orval T. Little</u>		Address <u>R.F.D.#2 Williamsport, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Leukemia, Myelocytic</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN DEATH AND DEATHS <u>two years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat White <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from <u>August 16, 1965</u> to <u>October 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>October 7, 1967</u> , and that death occurred at <u>11:20AM</u> on <u>October 7, 1967</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Archie Robert Cohen</u>		22b. DATE SIGNED <u>October 9, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u>		22d. ADDRESS <u>Clear Spring, Maryland 21722</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 10, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Williamsport Washington, Md.</u>
24. FUNERAL DIRECTOR <u>Albert I. Ioaf- 7 Church St. Williamsport, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 10 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

14558

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 8 Days		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Myersville d. STREET ADDRESS Rfd. 2 e. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Icie Ellen Ludy		4. DATE OF DEATH October 30, 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 22, 1899
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11 BIRTHPLACE (County & State or foreign country) Wolfesville, Md.		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME T. Keller Smith		14. MOTHER'S MAIDEN NAME Clemmie Schroyer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Lloyd C. Ludy, Rfd. 2 Myersville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 601X IMMEDIATE CAUSE (a) Arteriosclerosis DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's Disease and Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-22, 1967 , to 10-29 1967 , that (I) (we) last saw the deceased alive on 10-29 1967 , and that death occurred at 4:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Francis E. Rosillo		22b. DATE SIGNED 10-30-67	
22c. PHYSICIAN'S NAME (Type) FRANCIS E. ROSILLO		22d. ADDRESS 380 Northern Ave. Hagerstown	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-1-67	
23c. NAME OF CEMETERY OR CREMATORY Wolfesville Cemetery		23d. LOCATION (City or town) (County) (State) Wolfesville, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REG. STRAR NOV 6 1967	
25b. REG. STRAR'S SIGNATURE Orlando Judge			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14558

14569

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD b. COUNTY FR. GEORGES 6104 - 43 AVE. HYATTSVILLE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE MD			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL				d. STREET ADDRESS 6104 43RD AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ROSE Middle MARY Last HAUSER				4. DATE OF DEATH Month 10 Day 9 Year 1967			
5. SEX F	6 COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH APR 22 1909		9. AGE (In years last birthday) 58 yrs	IF UNDER 1 YEAR Months Days hours Min	
10a US JAIL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b KIND OF BUSINESS OR INDUSTRY OFFICE		11 BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE A. MAUSER				14 MOTHER'S MAIDEN NAME JENNIE C. HOHMAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 214 01 8744		17. INFORMANT Address ELIZABETH POHLMAN 16 MADELINE AVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GLIOBLASTOMA, MULTIFOCAL, BRAIN 172 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 3 mo.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EMBOLISM							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-3 , 1967, to 10-9 , 1967, that (I) (we) last saw the deceased alive on 10-9 , 1967, and that death occurred at 1:45A M, from causes and on the date stated above							
22a. SIGNATURE Domingo A. Garcia				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-9-67	
22c. PHYSICIAN'S NAME (Type) DOMINGO A. GARCIA				22d. ADDRESS 1500 PENNSYLVANIA AVE. HAGERSTOWN, MD.			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT 12 1967		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM		23d. LOCATION (City or Town) (County) (State) 4430 BELAIR RD MD.	
24 FUNERAL DIRECTOR THE DIPPEL BROS INC 7110 BELAIR RD				25a. REC'D BY REGISTRAR DATE OCT 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

14560

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MORGAN	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 8 HOURS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON CO. HOSPITAL		e. STREET ADDRESS HOTEL WASHINGTON	
3. NAME OF DECEASED (Type or print) SUE KATHLEEN MCAVOY		4. DATE OF DEATH Month OCTOBER Day 22 Year 1967	
5. SEX F	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/1891
9. AGE (in years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY 1812B-1741	
11. BIRTHPLACE (County & State, or foreign country) MORGAN CO., W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SIEBERT D. SHERRARD		14. MOTHER'S MAIDEN NAME MARY E. STOTLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-20-1714	
17. INFORMANT MRS. MARY B. WHEAT		18. ADDRESS 130 LONGSTREET AVE FREDERICKSBURG, VA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable aortic rupture DUE TO 51X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Accelerated cardiovascular disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above			
22a. SIGNATURE Wm. O. Rexrode M.D.		22b. DATE SIGNED 10/26/67	
22c. PHYSICIAN'S NAME (Type) Dr. William O. Rexrode		22d. ADDRESS 145 S. Prospect St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/25/67	23c. NAME OF CEMETERY OR CREMATORY HANCOCK PRESBYTERIAN	23d. LOCATION (City or Town) (County) (State) HANCOCK, WASH., MD.
24. FUNERAL DIRECTOR Richard J. Thorne		25a. REC'D BY REGISTRAR Hancock, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 30 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE PENNA. b COUNTY FRANKLIN ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b GREENCASTLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ON ARRIVAL WASHINGTON CO. HOSPITAL		e. STREET ADDRESS XXX 23 South Carlisle Stl	
3 NAME OF DECEASED (Type or print) Elizabeth Catherine Miller		4 DATE OF DEATH Month October Day 24 Year 1967	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/24/1907
9. AGE (In years lost birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY House work	
11. BIRTHPLACE (County & State, or foreign country) Franklin Co., Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clinton F. Hykes		14. MOTHER'S MAIDEN NAME Mary Oberholzer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 186-30-7038	
17 INFORMANT Mr. Fred Miller, Greencastle, Penna.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular Disease 443x DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 1, 1967 , to Oct. 24, 1967 , that (I) (we) last saw the deceased alive on Sept. 27, 1967 , and that death occurred at 11:30 A.M. from causes on and on the date stated above.			
22a SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 10-24-67	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.		22d. ADDRESS 215 W. Washington St., Hagerstown, Md.	
23a BURIAL CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 10/27/1967	23c NAME OF CEMETERY OR CREMATORY Welsh Run Brethern Cemetery	23d LOCATION (City or Town) (County) (State) Franklin Co., Penna.
24. FUNERAL DIRECTOR <i>[Signature]</i>		25a. REC'D BY REGISTRAR Oct 27 1967	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14562

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission). a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 340 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		e. STREET ADDRESS 36 ROESSNER Ave.	
3. NAME OF DECEASED (Type or print) First John Middle Stoner Last Miller		4. DATE OF DEATH Month Oct. Day 16 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1885
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months 2 Days 10 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY grocery store	
11. BIRTHPLACE (County & State or foreign country) Pennsylvania		12. CIT. ZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John H. Miller		14. MOTHER'S MAIDEN NAME Emma Stoner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-09-3264	
17. INFORMANT Mrs. Evelyn Conrad, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 157A IMMEDIATE CAUSE (a) general carcinomatosis DUE TO (b) carcinoma of rectum DUE TO (c) 13 mos.		INTERVAL BETWEEN ONSET AND DEATH 21 months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GI Paget's Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Nov. 10, 1966 to Oct. 16, 1967 , that (1) the saw the deceased alive on Oct. 16, 1967 , and that death occurred at 11:45 AM , from causes and on the date stated above.			
22a. SIGNATURE Victor L. Ramos, M.D.		22b. DATE SIGNED Oct. 16, 1967	
22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS, M.D.		22d. ADDRESS Western Md. State Hospital Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 10-19-67	23c. NAME OF CEMETERY OR CREMATORY Manor Cemetery	23d. LOCATION (City or Town) (County) (State) Tilghmanton, Md.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE OCT 20 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



14562

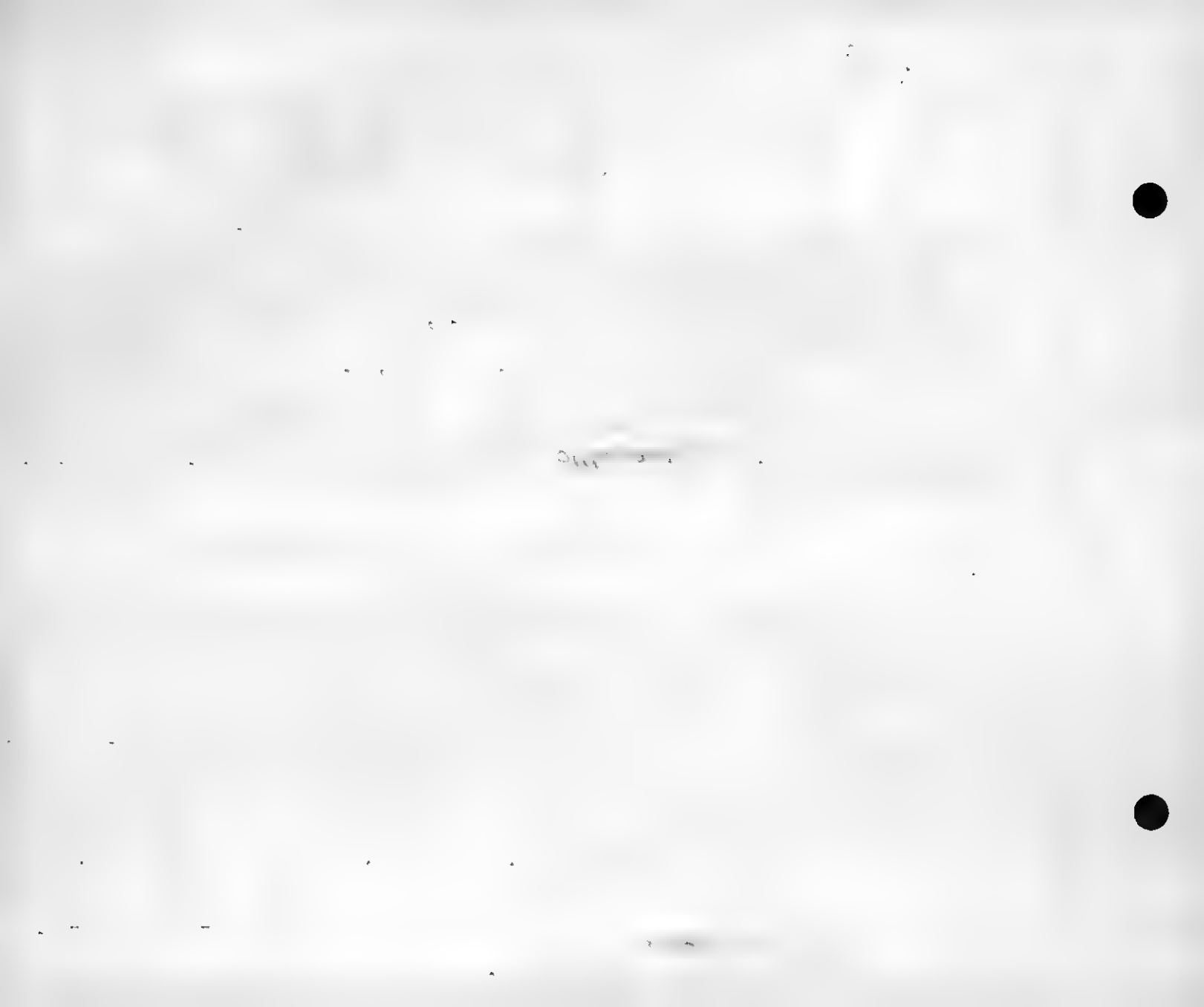
CERTIFICATE OF DEATH

14573

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u> c. LENGTH OF STAY IN 1b <u>55 yrs.</u>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Avalon Manor Nursing Home</u>		d. STREET ADDRESS <u>136 North Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Amis</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6, 1901</u> 9 AGE (in years last birthday) <u>66</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman Finishing Room</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pipe Organ Mfg.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Luray, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Early Moore</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bruffey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>1920-21-22</u>		16. SOCIAL SECURITY NO. <u>214-09-9110</u>	
17. INFORMANT <u>Thelma Andrews</u>		Address <u>136 North Ave. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cachexia</u> DUE TO (b) <u>adenocarcinoma of pancreas with metastasis</u> stating the underlying cause lost. (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>none</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug '61</u> , 19 <u> </u> , to <u>Oct 30 '67</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>Oct 1</u> , 19 <u>67</u> , and that death occurred at <u>PM</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Harold R. Tritch, Jr.</u>		22b. DATE SIGNED <u>11-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Harold R. Tritch, Jr M.D.</u>		22d. ADDRESS <u>302 N. Potomac St Hagerstown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/2/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>
24. FUNERAL DIRECTOR <u>Wm. C. Hunt</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 6 1967</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH

14564

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1967

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b 5 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 17 East Salisbury St.				d. STREET ADDRESS 17 East Salisbury St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grover		Middle Eugene		Last Moser		4. DATE OF DEATH Month Oct. Day 3rd. Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14th. 1898	9. AGE (In years last birthday) 73 yrs.	10. FINDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel E. Moser				14. MOTHER'S MAIDEN NAME Mary E. Summers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Dorothy Moser Williamsport Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular Pneumonia, Bilateral 490X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (c) DUE TO DUE TO DUE TO							INTERVAL BETWEEN ONSET AND DEATH 3-5 days 20 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Prostatic Hypertrophy, Benign							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Edward W. Dittman, M.D. 217 W. Washington St. Hagerstown				22. DATE SIGNED 10-3-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 6, 67		23c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery		23d. LOCATION (City, town or county) (State) St. Paul Wash. Md.	
24. FUNERAL DIRECTOR Thompson Funeral Home				25a. REC'D BY REGISTRAR OCT 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM 5/1
5M 1/65

<div>Item 21 Form 394 11-7-65</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>14565</div> <div>14575</div>											
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Allegeny					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 46 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL						d. STREET ADDRESS 209 Humbird St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dorothy Middle Marie Last Moss			4. DATE OF DEATH Month 10 Day 26 Year 1967								
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 18, 1913		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Allegeny, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Henry Brinkman						14. MOTHER'S MAIDEN NAME Katherine Woy					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Katherine Brinkman, Cumberland, Md.			Address Mother		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia Secondary DUE TO (b) Fracture of femur DUE TO (c) 4mons										INTERVAL BETWEEN ONSET AND DEATH 4mons	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in home							
20c. TIME OF INJURY Month, Day, Year Hour, e.m. 6/13/1967 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cumberland Alleg, Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Edward W. Dittus III						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 10-26-67		
EXAMINER'S NAME (Type) 217 W. Washington St Hagerstown						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct. 29, 1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery			23d. LOCATION (City, town or county) (State) Cumberland, Md. Allegeny		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 30 1967					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12500

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14576

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 1/2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 177 Manse Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Russell Last Mowry				4. DATE OF DEATH Month October Day 20 Year 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-15	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 2 Days 1	IF UNDER 24 HRS. Hours 1 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) engineer		10b. KIND OF BUSINESS OR INDUSTRY steel fabricati.		11. BIRTHPLACE (County & State, or foreign country) Derry, Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William R. Mowry				14. MOTHER'S MAIDEN NAME Dora Richardson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WWII		17. INFORMANT Geraldine Mowry, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Atherosclerosis of Coronary Arteries DUE TO (c) 2 1/2 yr. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH none	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/1/65 , 19 65 , to 10/21 , 19 67 , that (I) (we) last saw the deceased alive on 10/13 , 19 67 , and that death occurred at 2:55 PM , from the causes and on the date stated above.							
22a. SIGNATURE William O. Rexrode M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/21/67	
22c. PHYSICIAN'S NAME (Type) William O. Rexrode				22d. ADDRESS 1455 Prospect St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10-23-67		23c. NAME OF CEMETERY OR CREMATORY Coles Cemetery		23d. LOCATION (City, town or county) (State) Derry, Penna.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.				25a. REC'D BY REGISTRAR OCT 24 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

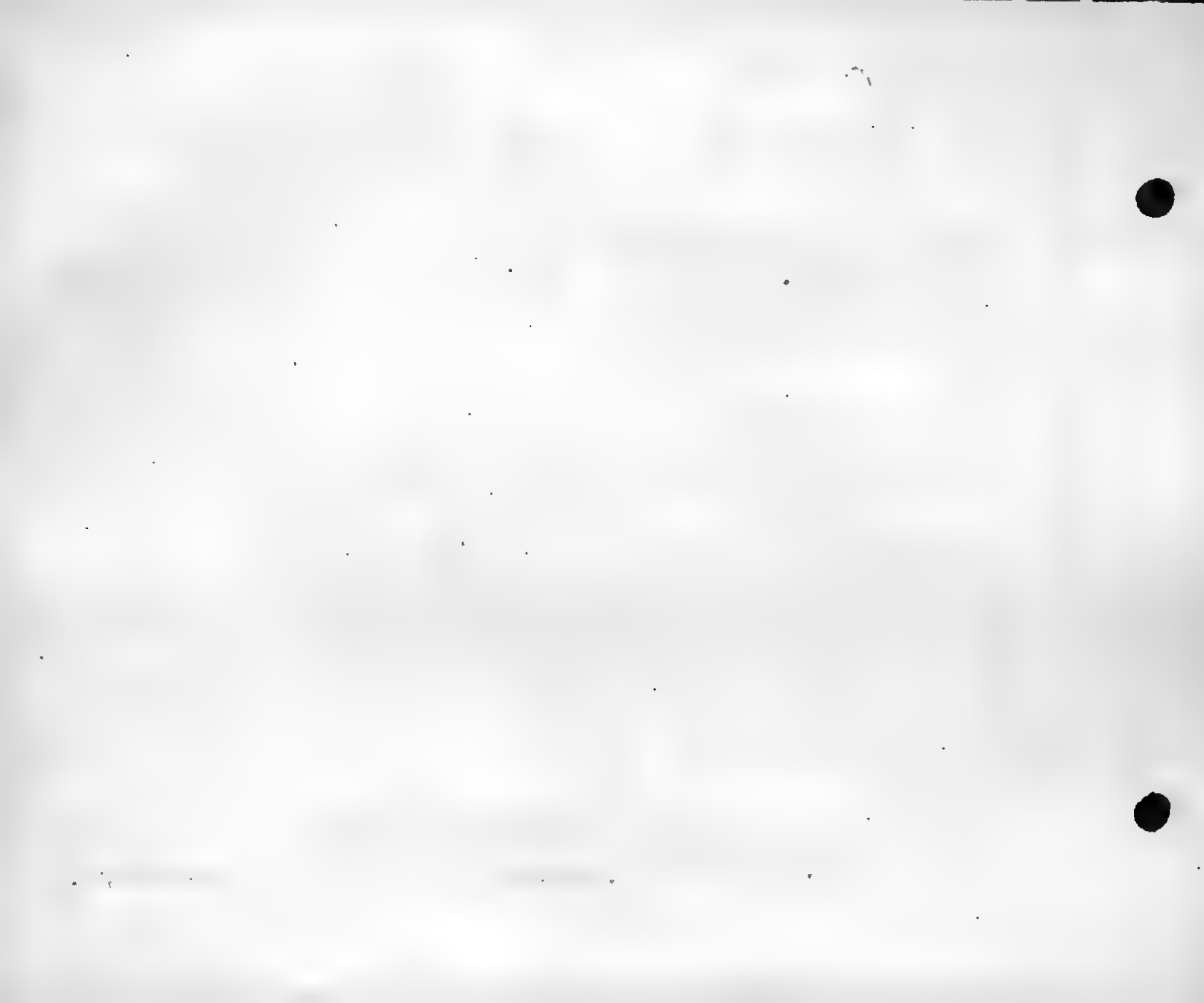
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1000. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

14561
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Clearspring, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLUMBUS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>133 So. WARREN</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dolores NMN Neighbors</u>		4. DATE OF DEATH Month Day Year <u>10 7 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-13-50</u>
9. AGE (In years last birthday) <u>17 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>WAITRESS</u>	11. BIRTHPLACE (State or foreign country) <u>COLUMBUS, Ohio</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Ralph Neighbors</u>	
14. MOTHER'S MAIDEN NAME <u>CLARA OSBURN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>RALPH NEIGHBORS COLUMBUS Ohio</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Depressed Skull fracture &</u> DUE TO (b) <u>Brain Stem Injury</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Furmed.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in At-Rest Seat Rake which Struck Trunk.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>12:30 pm</u> <u>10-7-1967</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>IS 70</u>	20f. (City or town) (County) (State) <u>W. Clearspring Wash. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Edward W. Ditto III</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Edward W. Ditto III</u>		22. DATE SIGNED <u>10-7-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/10/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MILES CEM.</u>		23d. LOCATION (City, town or county) (State) <u>PUTLAND Ohio</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Gerry Spears Columbus, Ohio</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>OCT 13 1967</u> <u>Charles Judge</u>	



14568

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14578

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport PFD #1</u>		c. LENGTH OF STAY IN 1b <u>10 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Falling Waters Road</u>		d. STREET ADDRESS <u>Falling Waters Road</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>HERBY</u> Last <u>NEWLIN, SR.</u>		4 DATE OF DEATH Month <u>Oct.</u> Day <u>22</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 25, 1929</u>
9 AGE (in years last birthday) <u>38</u> yrs		10 UNDER 1 YEAR Months <u>3</u> Days <u>26</u> Hours <u>11</u> Mins <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garage</u>	
11 BIRTHPLACE (State or foreign country) <u>Williamsport, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Enoch Newlin</u>		14 MOTHER'S MAIDEN NAME <u>Marie Clem</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>214-20-5744</u>	
17 INFORMANT <u>Gladys Newlin</u>		Address <u>Williamsport PFD #1</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Laceration</u> DUE TO (b) <u>Basal fracture of skull</u> DUE TO (c) <u>Basal fracture of skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fracture left tibia + fibula; Chest injuries</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Motorcycle in head-on collision with car</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>12:05</u> a.m. <u>p.m.</u> <u>Oct 22 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Williamsport Washington Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John A. Moran</u> M.D. EXAMINER'S NAME (Type) <u>JOHN A. MORAN</u>		22. DATE SIGNED <u>10/23/67</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>215 W. Washington St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 25, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Williamsport, Wash. Md.</u>	
24. FUNERAL DIRECTOR <u>Albert L. Leaf</u>		25a. REC'D BY REGISTRAR <u>Oct 24 1967</u>	
ADDRESS <u>Williamsport, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14560 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14579									
1 PLACE OF DEATH a COUNTY <u>Washington</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Washington</u>				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sharpsburg</u>			c LENGTH OF STAY IN ID <u>Lifetime</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sharpsburg</u>				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Antietam</u>					d STREET ADDRESS <u>Antietam</u>			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Floyd</u> ^{First} <u>Cecil</u> ^{Middle} <u>Pierce Sr.</u> ^{Last}					4 DATE OF DEATH Month <u>Oct.</u> Day <u>25</u> Year <u>1967</u>				
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>July 11 1929</u>		9 AGE (In years past birthday) yrs <u>38</u>	
10a USUAL OCCUPATION (Give kind of work done during most of work life even if retired) <u>Electric Worker</u>				10b KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George T. Pierce</u>					14. MOTHER'S MAIDEN NAME <u>Effie V Ely</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes World War 2</u>			16 SOCIAL SECURITY NO. <u>218 24 9595</u>		17. INFORMANT <u>Mrs. Hazel A. Pierce</u> Address <u>Antietam Sharpsburg</u> <u>1FD</u> <u>Id.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Hemorrhage from</u> <u>1919</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>lesion of Squamous Cell Carcinoma</u> (c) <u>into pulmonary vessels</u>								INTERVAL BETWEEN ONSET AND DEATH <u>16-30 hrs</u> <u>6-12 Mos.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u>					ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>				
					DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/> 22 DATE SIGNED <u>10-26-67</u>				
					Address (Street, city, town or county) <u>217 W. Washington St. Hagerstown, Md.</u>				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF <u>Oct. 28-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>1st. View Cemetery</u>		23d LOCATION (City or town) (County) (State) <u>Sharpsburg Washington</u>			
24 FUNERAL DIRECTOR <u>Albert L. Leaf Williar sport</u> Maryland					25a REC'D BY REGISTRAR DATE <u>OCT 31 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

14570

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14580

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>60 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. STREET ADDRESS <u>302 N. Cannon Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Dewey</u> Last <u>Pike</u>		4 DATE OF DEATH Month <u>October</u> Day <u>8</u> Year <u>19 67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 5, 1898</u>
9 AGE (In years last birthday) <u>69</u> yrs		FUNDING YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pattern Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dust Control Mfg.</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin County, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel J. Pike</u>		14. MOTHER'S MAIDEN NAME <u>Ida C. Wagner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-6607</u>	
17. INFORMANT <u>Chas. J. Pike</u>		Address <u>217 N. Cleveland Ave. Hagerstown, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Fractured Ribs, Right Chest With Hemo-</u> DUE TO <u>Pneumothorax</u> (b) <u>Multiple Fractures Of Pelvis With Pelvic</u> DUE TO <u>Retroperitoneal Hemorrhage</u> (c) <u>Fractured Right Leg (Tibia and Fibula)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 hours</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Struck by automobile while crossing street.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7:20</u> p.m. <u>10-6-</u> <u>1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Hagerstown</u> (County) <u>Washington</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. E. W. Ditto, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-9-67</u>	
		Address (Street, city, town, or county) <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u> ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 13 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

22. DATE SIGNED



CERTIFICATE OF DEATH

14581

14571

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Smithsburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>R # 2</u>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard Luther Plank</u>			4. DATE OF DEATH Month Day Year <u>October 19 19 67</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>March 11, 1904</u>		9. AGE (In years last birthday) <u>63</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Locomotive Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Gettysburg, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Roy Plank</u>				14. MOTHER'S MAIDEN NAME <u>Virgie May Plank</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-10-7654</u>		17. INFORMANT <u>Mrs. Ruth M. Plank R # 2 Smithsburg, Md.</u>		Address <u>Holiday Acres</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive pulmonary embolus</u> DUE TO (b) <u>Rt hemiplegia</u> DUE TO (c) <u>Acute cerebral vascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity & hypertension; diabetes</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>none</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>- - -</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 14</u> , 19 <u>66</u> , to <u>Oct 19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 19</u> , 19 <u>67</u> , and that death occurred at <u>P. M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Harold R. Tritch, Jr.</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>10-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harold R. Tritch, Jr M.D.</u>				22d. ADDRESS <u>302 N. Potomac St. Hagerstown, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u> <u>Rest Haven Funeral Chapel</u>				25a. REC'D BY REGISTRAR <u>DATE OCT 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>William C. Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14572

CERTIFICATE OF DEATH

14582

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write nearest town) HAGERSTOWN		c. LENGTH OF STAY in lb 48 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 224 N. POTOMAC ST.				d. STREET ADDRESS 224 N. POTOMAC ST.		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3 NAME OF DECEASED (Type or print) First JOSHUA Middle POFFENBERGER Last POFFENBERGER				4 DATE OF DEATH Month OCTOBER Day 29 Year 67			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/7/1901		9. AGE (In years birth day) 66 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life) BOOKBINDER		10b. KIND OF BUSINESS OR INDUSTRY PUBLISHING CO.		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JOSHIA POFFENBERGER				14. MOTHER'S MAIDEN NAME MARIA RENNER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv.) NO		16. SOCIAL SECURITY NO 214-09-1201		17. INFORMANT Address MRS. JEAN GETTEL HAGERSTOWN MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from Oct 29, 1966 to Oct 29, 1967 that (I) (we) lost saw the deceased alive on Oct 21, 1967 and that death occurred at 2 P M, from causes and on the date stated above.							
22a. SIGNATURE Sidney Novenstein		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10-30-67			
22c. PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN		22d. ADDRESS FUNKSTOWN MD					
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE THEREOF 11/1/67	23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		23d. LOCATION (City or town) HAGERSTOWN		(County) WASH.	(State) MD.
24. FUNERAL DIRECTOR W. J. Normant, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE NOV 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14573

CERTIFICATE OF DEATH

14583

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 35 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont rural		10 IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS RD 2	
3 NAME OF DECEASED (Type or print) Catherine Marie Portner		4 DATE OF DEATH Month Oct. Day 4 Year 19 67	
5 SEX Female	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-16-1922
9. AGE (In years last birthday) 44 yrs		11. BIRTHPLACE (County & State, or foreign country) Maryland	
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
13. FATHER'S NAME Guy Manahan		14. MOTHER'S MAIDEN NAME Jennie A. Willard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-58-9531	
17 INFORMANT Lee F. Portner		Address Thurmont, Md. RD 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Brondhogenic carcinoma with generalized metastases DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 4 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 2-8, 1966 , to 10-4, 1967 , that (I) (we) last saw the deceased alive on 10-4 19 67 , and that death occurred at 9-40 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Charles F. Hess</i>		22b. DATE SIGNED 10-5-67	
22c. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.		22d. ADDRESS Smithsburg, Maryland 21783	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-7-67	23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery	23d. LOCATION (City or Town) (County) (State) Thurmont Fred. Co. Md.
24. FUNERAL DIRECTOR <i>Raymond E. Creager</i>		25a REC'D BY REGISTRAR DATE OCT 9 1967	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

CERTIFICATE OF DEATH

14584

14574

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon top and bottom pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 3 1/2 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First MAYMIA Middle MARIE Last POWERS		4 DATE OF DEATH Month OCTOBER Day 13 Year 19 67	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/07/09
9 AGE (In years last birthday) 58 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) MEALLY KENTUCKY		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME GROVER MUSIC		14 MOTHER'S MAIDEN NAME MERIDAL WEBB	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 402-64-7794	
17. INFORMANT EDWARD J POWERS		113 BROADWAY HAGERSTOWN MARYLAND	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypostatic pneumonia DUE TO (b) Multiple small pulmonary emboli DUE TO (c) Perforance of gastro-duodenostomy		INTERVAL BETWEEN ONSET AND DEATH 3 wks.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the physician) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Thomas V Craig		22b. DATE SIGNED 10/16/67	
22c. PHYSICIAN'S NAME (Type) THOMAS V CRAIG M. D.		22d. ADDRESS 247 N POTOMAC ST. HAGERSTOWN MARYLAND	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/18/67	23c. NAME OF CEMETERY OR CREMATORY U.S. GOV'T CEMETERY	23d. LOCATION (City or Town) (County) (State) GETTYSBURG PENNA.
24. FUNERAL DIRECTOR CHARLES M ROUZER HAGERSTOWN MARYLAND		25a. REC'D BY REGISTRAR OCT 19 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles J. [unclear]</i>	

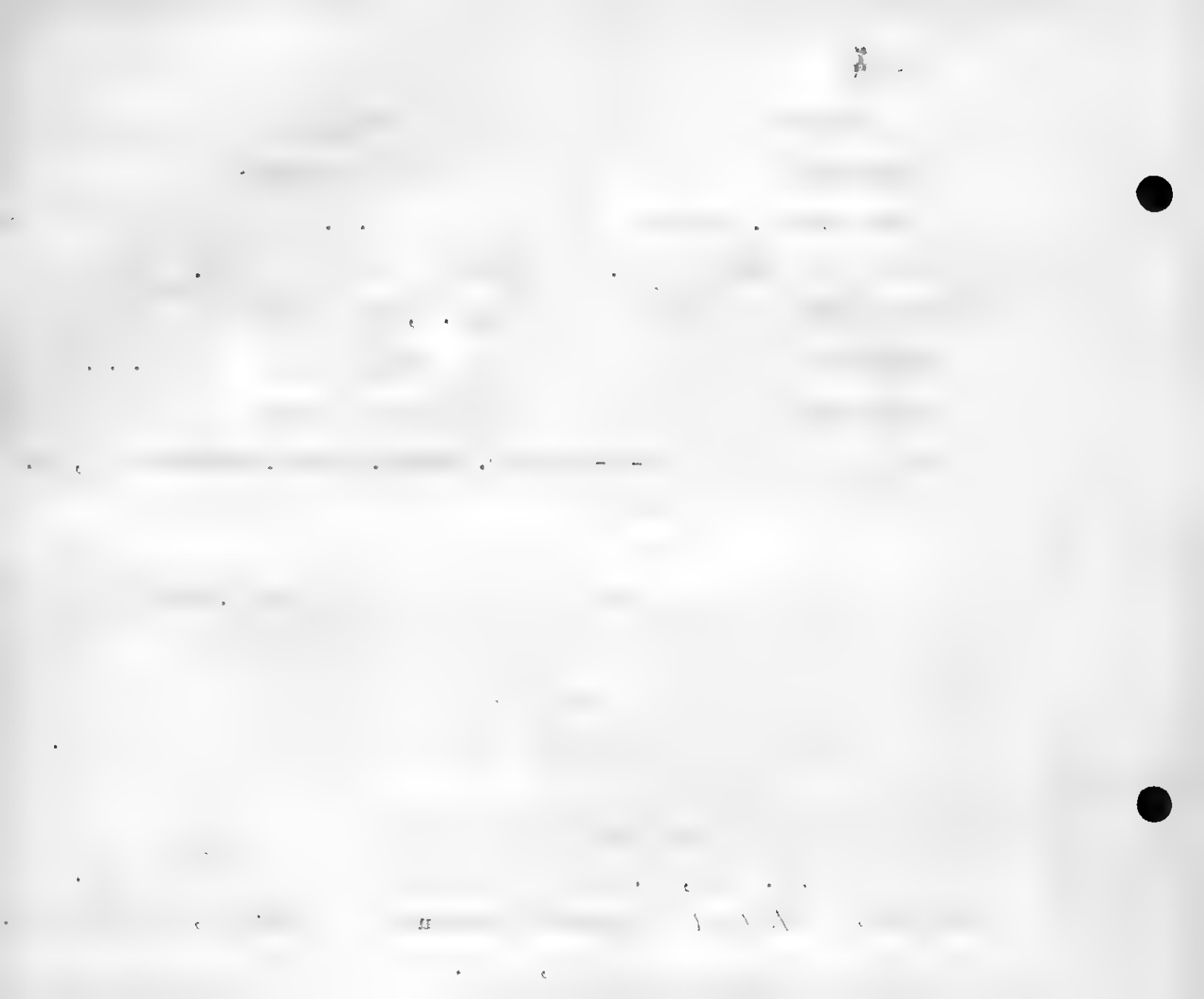
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files.

TO BURIAL DIRECTOR: Page 3 should be submitted as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 77 hours after death.

VR A15ME (5)
6M 1/67

<div>14571</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>14585</div>											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 9 wks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Smithsburg					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital						d. STREET ADDRESS R. D. 3				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Emma C. Ridenour						4. DATE OF DEATH Month Day Year Oct. 13 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 5, 1879		9. AGE (in years last birthday) yrs 88		F UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abram Weddle						14. MOTHER'S MAIDEN NAME Mary Alice Stouffer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO 215-36-6947B		17. INFORMANT Mr. David M. Ridenour				Address Smithsburg #3, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Pneumonitis Several days DUE TO (b) Fracture Of Right Femur 13 days DUE TO (c) Arteriosclerotic Cardio Vascular Disease. Several years											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Fell in her home.							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 8-8 1967				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street office bldg. etc.) Home		20f. (City or town) (County) (State) Smithsburg, Washington, Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr. M.D.						22. DATE SIGNED 10-13-67 Address (Street city town or county) Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment				23b. DATE THEREOF 10/15/1967		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Mausoleum				23d. LOCATION (City or town) (County) (State) Smithsburg, Washington, Md.	
24. FUNERAL DIRECTOR Willie J. Grace Waynesboro, Penna.						25a. REC'D BY REGISTRAR OCT 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

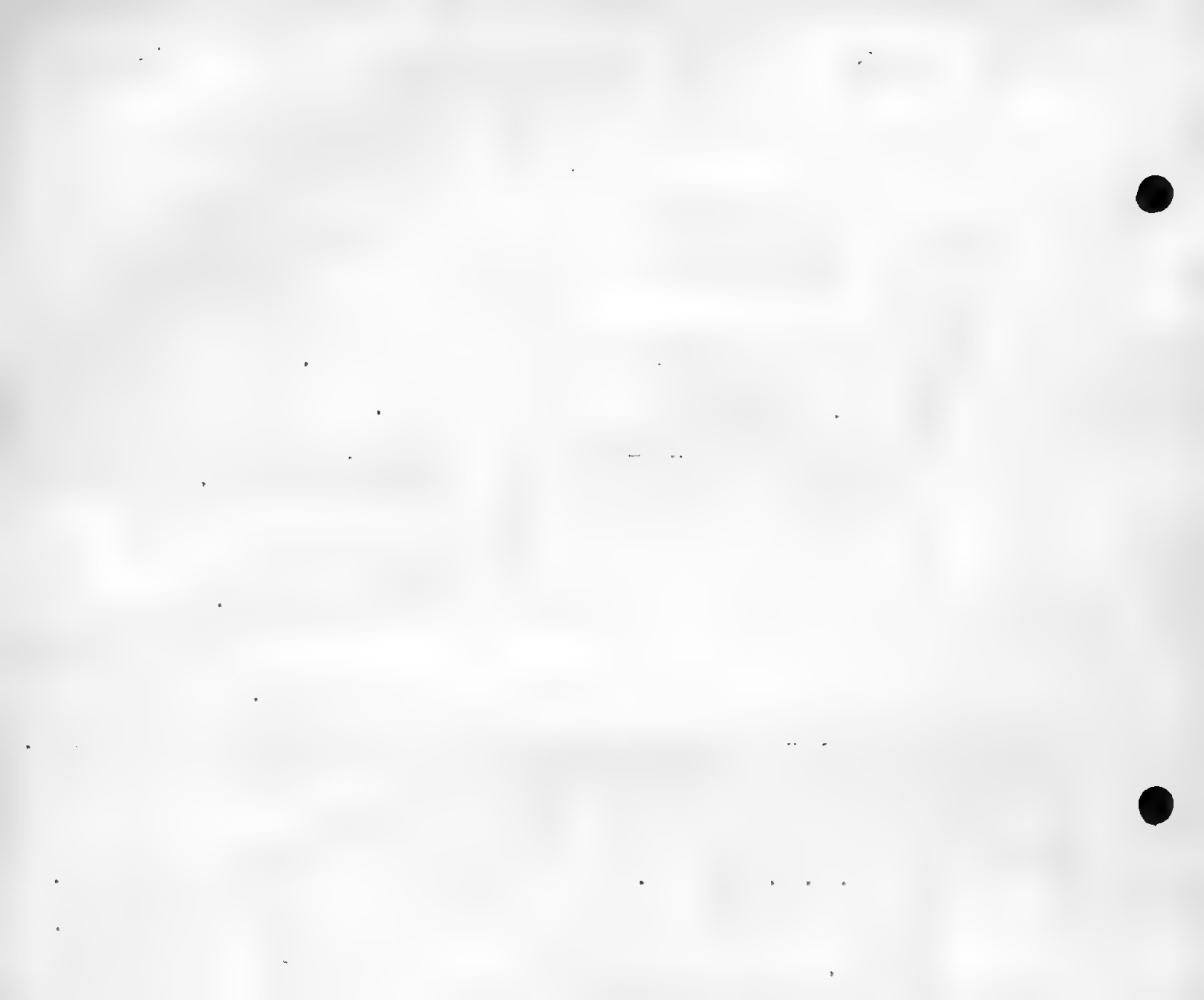
VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14586

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 8 Weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) MILDRED MARY ROEDIGER		4 DATE OF DEATH Month Day Year Oct 14 1967 19	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 3 1885
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) St Louis Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob C. Roediger		14. MOTHER'S MAIDEN NAME Emma C. Oldendolph	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 345-10-5061 A	
17. INFORMANT Rev Mark Wagner Homewood Church Home		Address williamsport Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture Of Femur DUE TO (c) Arteriosclerotic Cardio Vascular Disease, Several years		INTERVAL BETWEEN ONSET AND DEATH Several days 14 days Several years	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Misstepped from building onto pavement.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:30 9-30- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Hagerstown, Washington, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		22. DATE SIGNED 10-14-67 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/17/67	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR Hagerstown Md Andrew K. Coffman Funeral Home Inc		25a. REC'D BY REGISTRAR OCT 18 1967 25b. REGISTRAR'S SIGNATURE 	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

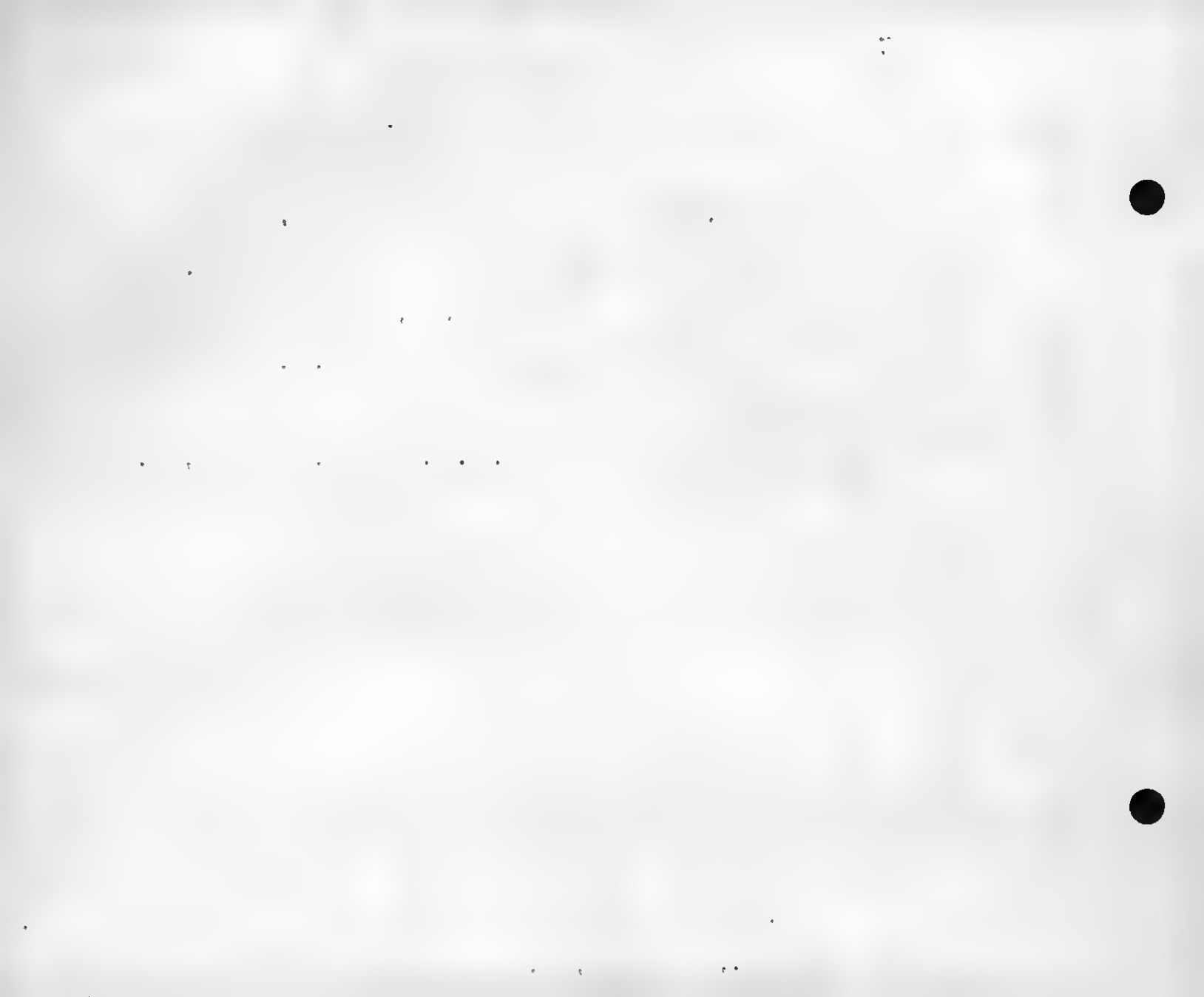
14587

14577

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg		c. LENGTH OF STAY IN lb 31 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 29 South Main St.				d. STREET ADDRESS 29 South Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alene Middle Moore Last Schultz				4. DATE OF DEATH Month Oct. Day 18 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1892		9. AGE (In years last birthday) 75 yrs	10. IF UNDER 1 YEAR Months 10 Days 7 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Hammonton, N. J.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Willits				14. MOTHER'S MAIDEN NAME Imogene Crowley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mr. R. G. Schultz, Smithsburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute pulmonary E of emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Parkinson's disease DUE TO (c) Arterio sclerosis				INTERVAL BETWEEN ONSET AND DEATH 10 yrs 15 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 14, 1967 to Oct 18, 1967 that (I) (we) last saw the deceased alive on Oct 18, 1967 and that death occurred at 8 A.M. from causes and on the date stated above							
22a. SIGNATURE Geo. G. Kohler M.D.				22b. DATE SIGNED 10-19-67		22c. PHYSICIAN'S NAME (Type) Geo. A. Kohler	
22d. ADDRESS Smithsburg		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 21, 1967		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION (City or town) (County) (State) Smithsburg Washington Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home., Smithsburg, Md.				25a. REC'D BY REGISTRAR OCT 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14578 14588

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>W. Virginia</u> b COUNTY <u>Jefferson</u> ✓	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sandy Hook</u>		c LENGTH OF STAY IN 1b <u>3-4 hours</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS <u>RFD 1</u>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>(NMN)</u> Last <u>Seaman</u>		4 DATE OF DEATH Month <u>Approx. 10</u> Day <u>26</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>10-12-15</u>
9 AGE (In years last birthday) yrs <u>52</u>		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		10b KIND OF BUSINESS OR INDUSTRY <u>body shop</u>	
11 BIRTHPLACE (State or foreign country) <u>Oak Hill, W. Va.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Ernest Seaman</u>		14 MOTHER'S MAIDEN NAME <u>Mary J. Weinstanley</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>077-01-6946</u>	
17 INFORMANT <u>Mrs. Earl Toney, Wilmington, Dela.</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration of gastric contents.</u> DUE TO (b) <u>Massive Fracture left Temporal Bone & Zygomatic Process & Laceration of Left Temporal lobe & Subdural Hematoma.</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Approx. 2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		9 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell from small Embankment into Rocky Stream bed</u>	
20c TIME OF INJURY Month, Day, Year <u>App. 10:20 pm 10-26-1967</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Rural Road</u>		20f (City or town) (County) (State) <u>Sandy Hook Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Edward W. Dito III</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Edward W. Dito III, Hagerstown Md</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b DATE THEREOF <u>11-1-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Silverbrook Cem.</u>		23d LOCATION (City or Town) (County) (State) <u>Wilmington, Dela.</u>	
24 FUNERAL DIRECTOR <u>Minnich Funeral Home, Hagerstown, Md.</u>		25a REC'D BY REGISTRAR <u>NOV 2 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles J. ...</u>		22. DATE SIGNED <u>10-30-67</u>	



CERTIFICATE OF DEATH

14589

12578

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY in 1b 24 mo.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL				d. STREET ADDRESS 4824 EASTERN LANE, SUITLAND MD.			
3. NAME OF DECEASED (Type or print) First PHYLLIS Middle M. Last SEBENS				4. DATE OF DEATH Month 10 Day 7 Year 1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-18-12		9. AGE (In years last birthday) 54 yrs	12. CITIZEN OF WHAT COUNTRY? USA.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY HOSPITAL		11. BIRTHPLACE (County & State, or foreign country) MICHIGAN		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME FRANK COOPER				14. MOTHER'S MAIDEN NAME FLORENCE BROOKS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) *****		16. SOCIAL SECURITY NO.		17. INFORMANT Address MRS. FLORENCE COOPER, VANDALLIA, MICHIGAN			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) AMYOTROPHIC LATERAL SCLEROSIS DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 2 YRS, 7 MOS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-25 , 19 65 , to 10-7 , 19 67 , that (I) (we) last saw the deceased alive on 10-7 , 19 67 , and that death occurred at 10:40 PM , from causes and on the date stated above.							
22a. SIGNATURE Domingo A. Garcia				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-7-67	
22c. PHYSICIAN'S NAME (Type) DOMINGO A. GARCIA				22d. ADDRESS 1500 PENNSYLVANIA AVE. HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 10/8/67		23c. NAME OF CEMETERY OR CREMATORY POES CEMETERY		23d. LOCATION (City or Town) (County) (State) CASS CO. MICHIGAN	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.				25a. REC'D BY REGISTRAR OCT 10 1967		25b. REGISTRAR'S SIGNATURE Walter J. J...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 14590

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 56 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 200 Pangborn Blvd.				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 200 Pangborn Blvd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sarah Myrtice Settles				4. DATE OF DEATH Month Day Year October 17, 1967					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-30-91		9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Warren Co., Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Aureluis Lawson						14. MOTHER'S MAIDEN NAME Lillie Jennings			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT James D. Settles, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic mellitus & diabetic neuropathy								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June 19, 1962, to Oct. 17, 1967, that (I) (we) last saw the deceased alive on Oct. 12, 1967, and that death occurred at 7:00 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Edson B. Moody								22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Edson B. Moody						22d. ADDRESS 145 S. Prospect St. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10-20-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.		
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.						25a. REC'D BY REGISTRAR OCT. 20 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

CERTIFICATE OF DEATH

14591

14581

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE xxxx Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
c. LENGTH OF STAY IN 1b 4 months		d. STREET ADDRESS 312 Eldrid Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marie Louise Shand		4. DATE OF DEATH Month 10 Day 5 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1924
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Medicine Nat'l Library of	
11. BIRTHPLACE (County & State, or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Paul Pringre		14. MOTHER'S MAIDEN NAME Jeanne Eisenbach	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Fred E. Shand		Address 312 Eldrid Drive Silver Spring, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia DUE TO (b) Cerebral vascular accident DUE TO (c) 1 1/2 yrs		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-23 , 19 67 to 10-5 , 19 67 , that (I) (we) last saw the deceased alive on 10-5 , 19 67 , and that death occurred at 12:20 PM , from causes and on the date stated above			
22a. SIGNATURE Edwin G. Kiley M.D.		22b. DATE SIGNED 10-5-67	
22c. PHYSICIAN'S NAME (Type) Edwin G. Kiley		22d. ADDRESS Western State Hospital, Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 7, 1967	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 9 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar or to burial or cremation, or removal.

VS. A15ME(S)
SM 9/55

1-582										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										1-582																			
1. PLACE OF DEATH										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)										Reg. Dist. No.																			
a. COUNTY Washington					MARYLAND					a. STATE Maryland					b. COUNTY Washington																								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sharpsburg					c. LENGTH OF STAY IN 1b Minutes					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg, Md.					* / - /																								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 65- Auto accident										d. STREET ADDRESS 112 S. Mechanic St.										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print)										4. DATE OF DEATH																													
First Middle Last Josiah Irvin Sheffler										Month Day Year Oct. 21 1967																													
5. SEX Male			6. COLOR OR RACE White			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH April 1, 1914			9. AGE (In years last birthday) 23 yrs.			IF UNDER 1 YEAR Months Days Hours Min. 6 2			IF UNDER 24 HRS.																					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator										10b. KIND OF BUSINESS OR INDUSTRY Finishing & Dye Co.										11. BIRTHPLACE (State or foreign country) Maryland										12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Paul Sheffler										14. MOTHER'S MAIDEN NAME Rayetta (last name not known)																													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No										16. SOCIAL SECURITY NO. 212-14-3162										17. INFORMANT Vickie A. Sheffler										Address Sharpsburg, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Laceration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of base of skull</u> DUE TO (c) <u>"</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>																													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile struck guard rail on a curve</u>																													
20c. TIME OF INJURY Hour o. m. 4:05 p.m.										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) Street										20f. (City or town) (County) (State) Sharpsburg Washington Md									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .																																							
ACTUAL SIGNATURE <u>John A. Moran M.D.</u>										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>										DATE SIGNED 10/23/67																			
EXAMINER'S NAME (Type) JOHN A. MORAN										acting DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										22b. DATE THEREOF Oct. 24, 1967										22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery										22d. LOCATION (City, town, or county) (State) Sharpsburg Maryland									
23. FUNERAL DIRECTOR'S SIGNATURE Albert I. J. J.										ADDRESS Williamsport, Maryland										24a. REC'D BY REGISTRAR DATE OCT 24 1967										24b. REGISTRAR'S SIGNATURE <u>John A. Moran</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14583

Item #3 File #G394 10/27/67

14593

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tarpley</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Williamsport Md. 154 Martigan St.</u>		d. STREET ADDRESS <u>HI</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Magdalene Sherwin</u>		4. DATE OF DEATH <u>October 22 1967</u>	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 23, 1883</u>
9. AGE (in years lost birthday) <u>84 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>14</u> Hours <u>14</u> Min <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Prince George Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Underwood</u>		14. MOTHER'S MAIDEN NAME <u>Anna Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Sarah Linnell M. Williamsport Md</u>		Address <u>30 Tammany Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO (b) <u>Atherosclerotic Cardiovascular</u> DUE TO (c) <u>disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mins</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>19</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>M. Byrkit</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>M. Byrkit, M. D.</u>		22d. ADDRESS <u>Williamsport, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Oct. 25 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>HAGERSTOWN WASH CO MD</u>	
24. FUNERAL DIRECTOR <u>John N. Bart</u>		25a. REC'D BY REGISTRAR <u>Boonsboro MD</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 26 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14594

15584

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a STATE MARYLAND b COUNTY WASHINGTON	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c LENGTH OF STAY IN lb 4 YRS.	
d NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d STREET ADDRESS 1905 KNOTTY PINE DR.	
3. NAME OF DECEASED (Type or print) First Middle Last FREDERICK SHIELDS SR.		4. DATE OF DEATH Month Day Year OCTOBER 29 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10/5/1895
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b KIND OF BUSINESS OR INDUSTRY MACHINERY MFG.	11. BIRTHPLACE (County & State, or foreign country) NOTH IRELAND
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME ALFRED SHIELDS	
14. MOTHER'S MAIDEN NAME MARGARET McMULLEN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. 150-03-7997		17. INFORMANT MRS. HELEN SHIELDS MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac Arrest - Secondary to</u> DUE TO (b) <u>Extensive abdominal Hemorrhage from</u> DUE TO (c) <u>ruptured aortic aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>45 min.</u> <u>18-20 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND TION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 25, 1967</u> to <u>OCT 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>OCT 29, 1967</u> , and that death occurred at <u>5:10 P.M.</u> from causes and on the date stated above.			
22a SIGNATURE <u>Edward W. Ditto, III, M.D.</u>		22b DATE SIGNED <u>10-30-67</u>	
22c PHYSICIAN'S NAME (Type) Edward W. Ditto, III, M.D.		22d ADDRESS 217 W. Washington St. Hagerstown, Maryland	
23a BURIAL, CREMATION BURIAL	23b DATE THEREOF 10/31/67	23c NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.	23d LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.
24 FUNERAL DIRECTOR <u>W. J. Normant Hagerstown, Md.</u>		25a REC'D BY REGISTRAR DATE NOV 2 1967	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>



14585

CERTIFICATE OF DEATH

14595

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 15 HRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle MARGARET Last SHIVES		4. DATE OF DEATH Month 10 Day 26 Year 19 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 6. 1906
9. AGE (In years last birthday) yrs. 60		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY SAME	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON COUNTY MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM E BEARD		14. MOTHER'S MAIDEN NAME MARY M. MILLS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT ALFRED E SHIVES BIG POOL MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Coronary artery atherosclerosis with occulison Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Hypertension (b) 24 hours (c) 24 hours unknown		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this physician) attended the deceased from 10/25/67 , 19 10/26/67 , that (I) (we) last saw the deceased alive on 10/26/67 , 19 10/26/67 , and that death occurred at 6:35 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Archie Robert Cohen</i>		22b. DATE SIGNED Oct. 27. 1967	
22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.		22d. ADDRESS Clear Spring, Md. 21722	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10.28.67	
23c. NAME OF CEMETERY OR CREMATORY PARK HEAD		23d. LOCATION (City or Town) (County) (State) BIG POOL WASHINGTON MD.	
24. FUNERAL DIRECTOR <i>Howard H. Hume</i>		25a. REC'D BY REGISTRAR NOV 1 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14586

14596

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 212 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Charles Middle Victor Last Smith		4 DATE OF DEATH Month Oct. Day 1 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1885
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHEET METAL WORKER		10b. KIND OF BUSINESS OR INDUSTRY CEMENT MFG.	
11. BIRTHPLACE (County & State, or foreign country) Washington County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Smith		14. MOTHER'S MAIDEN NAME Sarah Moats	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO ****		16. SOCIAL SECURITY NO 213-10-6865A	
17. INFORMANT MR. PAUL V. SMITH, SMITHSBURG, MARYLAND.		18. BOX 25 Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cor pulmonale DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary emphysema DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH unknown 10 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (1) Arteriosclerotic Heart Disease (2) Arteriolosclerosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from MARCH 23, 1967 to OCT. 1, 1967 , that (1) (we) saw the deceased alive on OCT. 1, 1967 , and that death occurred at 3:23 P.M. from causes and on the date stated above			
22a. SIGNATURE Victor L. Ramos, M.D.		22b. DATE SIGNED OCT. 2, 1967	
22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS, M.D.		22d. ADDRESS Western Md. State Hospital Hagerstown, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/4/67	
23c. NAME OF CEMETERY OR CREMATORY MOUNTAIN VIEW CEMETERY		23d. LOCATION (City or Town) (County) (State) SHARPSBURG, WASH. CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR OCT 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14587

CERTIFICATE OF DEATH

14597

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst. at an Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u>		c. LENGTH OF STAY IN 16 <u>25 Yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>123 W. Main Street</u>		d. STREET ADDRESS <u>123 W. Main Street</u>	
3 NAME OF DECEASED (Type or print) <u>CLIFTON</u> First <u>IVY</u> Middle <u>SMITH</u> Last		4 DATE OF DEATH Month <u>Oct.</u> Day <u>16</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28 1911</u>
9 AGE (In years last birthday) <u>56</u> yrs		IF UNDER 1 YEAR Months <u>~</u> Days <u>17</u>	IF UNDER 24 HRS Hours <u>~</u> Min <u>~</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bank</u>	11 BIRTHPLACE (County & State, or foreign country) <u>Bakles Mills Maryland</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Clarence L. Smith</u>	
14 MOTHER'S MAIDEN NAME <u>Gay Fisher</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO <u>274-09-1063</u>		17 INFORMANT <u>Mrs. Mary C. Smith</u> <u>123 W. Main St., Sharpsburg, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>7.1.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 25, 1966</u> to <u>Sept 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 15</u> 1967, and that death occurred at <u>6:45 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Rizalito Amarillo</u>		22b. DATE SIGNED <u>OCT 16, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>RIZALITO AMARILLO</u>		22d. ADDRESS <u>Sharpsburg, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Oct. 18-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. View Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Sharpsburg, Washington Md.</u>
24 FUNERAL DIRECTOR <u>Albert I. Leaf</u>		25a. REC'D BY REGISTRAR <u>OCT 20 1967</u>	
ADDRESS <u>7 Church St. Williamsport Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14588

CERTIFICATE OF DEATH

14598

1 PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 hr d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 50 East Antietam St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) HARRY WILLIAM SMITH		4 DATE OF DEATH Month October Day 7 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1889
9. AGE (In years last birthday) 77 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Wash. Cty., Md. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME No Record		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no ---		16. SOCIAL SECURITY NO 214-09-1762A	
17. INFORMANT Mrs. Virginia McClelland		Address 50 E. Antietam St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) Hypertensive cardiovascular disease with congestive failure DUE TO (c) Indefinite INTERVAL BETWEEN ONSET AND DEATH 1 hr. 20 min.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4701			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat White <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) October 7, 1967	20f. (City or town) (County) (State) October 7, 1967
21. I certify that (I) (this hospital) attended the deceased from October 7, 1967 , to October 7, 1967 , that (I) (we) last saw the deceased alive on October 7, 1967 , and that death occurred at 7:50p. M, from causes on and on the date stated above			
22a. SIGNATURE B. B. Kneisley		22b. DATE SIGNED 10/9/67	
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22d. ADDRESS 148 West Washington Street Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/10/67	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City or town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home, Inc		25a. REC'D BY REGISTRAR OCT 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14599

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON CO. HOSPITAL		d. STREET ADDRESS 20 EAST WASHINGTON ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NELLIE REBECCA SPIELMAN		4. DATE OF DEATH Month Day Year OCTOBER 25, 1967			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH MARCH 5, 1890		9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHARLES D. BURNETT		14. MOTHER'S MAIDEN NAME LILY RANDALL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-14-2745		17. INFORMANT Address MISS DORIS I. BURNETT, HAGERSTOWN, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subcapital fracture Femur + Secondary to - Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Advanced Atherosclerosis, generalized (c) + Atherosclerotic Heart Disease & Failure		INTERVAL BETWEEN ONSET AND DEATH 10 days 20 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from bed at Nursing Home.			
20c. TIME OF INJURY Month, Day, Year Hour, a.m. 6:00 p.m. 10/16/1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing Home	
20f. (City or town) N. Hagerstown Wash. Rd.		20g. (County) Washington		20h. (State) MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Edward W. Ditto, III, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 10/30/67	
EXAMINER'S NAME (Type) EDWARD W. DITTO, III, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		217 W. WASH. ST.	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 10/30/67		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY	
23d. LOCATION (City, town or county) WASHINGTON		23e. (State) D.C.			
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MD.		25. RECEIVED BY REGISTRAR NOV 2 1967		26. REGISTRAR'S SIGNATURE Charles Judge	

Film, 6394- 11/3/67 - Originally reported on
regular certificate and should have been on A.E.
MB.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 4 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANCOCK d. STREET ADDRESS 8 TALIFERRO ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last OTIS WINFRED STANLEY				4. DATE OF DEATH Month Day Year OCTOBER 15, 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/24/1910		9. AGE (In years lost birthday) yrs. 57	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCKING		10b. KIND OF BUSINESS OR INDUSTRY TRUCKING		11. BIRTHPLACE (County & State, or foreign country) PAGE COUNTY, VIRGINIA U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARVEY ALFRED STANLEY				14. MOTHER'S MAIDEN NAME HETTE MAUDE EPPARD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 212-14-6541		17. INFORMANT MARTHA E. STANLEY HANCOCK, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO (b) <u>Appendiceal abscess</u> DUE TO (c) <u>4 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10/10/67 , 19 67 , to 10/15/67 , 19 67 , that (I) (we) lost saw the deceased alive on 19 , and that death occurred at M , from causes and on the date stated above.							
22a. SIGNATURE <i>Solomon R. Marsh</i> M.D.			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10/16/67		
22c. PHYSICIAN'S NAME (Type) Dr. John R. Marsh			22d. ADDRESS 247 N. Potomac St. Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/18/67		23c. NAME OF CEMETERY OR CREMATORY ST. THOMAS EPISCOPAL		23d. LOCATION (City or Town) (County) (State) HANCOCK WASH., MD.	
24. FUNERAL DIRECTOR <i>Howard F. Stone</i>			ADDRESS HANCOCK, MD.		25a. REC'D BY REGISTRAR OCT 20 1967 DATE		
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



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3
4592
14601
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14601

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admision) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Avalon Manor Nursing Home</u>		e. STREET ADDRESS <u>920 Hamilton Blvd.</u>	
3 NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Louise</u> Last <u>Starr</u>		4 DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 22, 1878</u>
9. AGE (in years last birthday) <u>89</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Bitzell Cobb</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Kansler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>220-34-0932A</u>	
17. INFORMANT <u>Mrs. John P. Coblentz</u>		Address <u>801 Rolling Road, Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Indefinite</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>Dec. 8</u> , 19 <u>61</u> , to <u>Oct. 7</u> , 19 <u>67</u> , that <u>we</u> (we) last saw the deceased alive on <u>Oct. 6</u> , 19 <u>67</u> , and that death occurred at <u>5:20P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>B. B. Kneisley</u>		22b. DATE SIGNED <u>10/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>		22d. ADDRESS <u>148 West Washington Street Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>
24. FUNERAL DIRECTOR <u>Wm. G. Horst</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>Oct 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a file burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14592											
14602											
1. PLACE OF DEATH a. COUNTY <u>Maryland</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN 1b <u>1 yr. 5 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport Sanitarium</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Berkeley</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Inwood, Box 52</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Lee</u> Last <u>Staub</u>						4. DATE OF DEATH Month <u>Oct</u> Day <u>19</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 30, 1883</u>		9. AGE (in years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>10</u> Hours <u>43</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Wh. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>George William Hill</u>						14. MOTHER'S MAIDEN NAME <u>Anno Virginia Reynolds</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Ruth Bomsher - Williamsport Md.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 7330 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Cardiovascular disease</u> 10 yrs (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (1) (this hospital) attended the deceased from <u>April 1, 1966</u> to <u>Oct 13, 1967</u> that (1) (we) last saw the deceased alive on <u>Oct 19, 1967</u> and that death occurred at <u>8:02</u> M, from the causes and on the date stated above.				22a. SIGNATURE <u>M.E. Bynkit</u>			
22b. DATE SIGNED <u>Oct 13</u>				22c. PHYSICIAN'S NAME (Type) <u>M.E. Bynkit</u>				22d. ADDRESS <u>Williamsport Md.</u>		22e. M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>10-15-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rosedale Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>MARTINSBURG W.VA.</u>		24. FUNERAL DIRECTOR <u>Edward K. Brown</u>	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>				25b. REGISTRAR'S SIGNATURE		DATE <u>OCT 16 1967</u>					

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 PLACE OF DEATH a COUNTY Washington b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c LENGTH OF STAY IN TB 2 Hr.						2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Washington c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Boonsboro, Md					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital						e STREET ADDRESS Toms Road f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3 NAME OF DECEASED (Type or print) OSCAR FRANCIS STONER						4 DATE OF DEATH Oct 23 1967					
5. SEX Male		6 CO. OR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Oct 4 1920		9 AGE (In years lost birthday) 47 yrs.		10 UNDER 1 YEAR Months Days Hours Min	
10a US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Drived				10b K IND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Pa. Greencastle Franklin Co USA			
13 FATHER'S NAME Oscar H. Stoner						14 MOTHER'S MAIDEN NAME Sarah Florence					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)				16 SOC. AL. SECURITY NO 220-10-3331		17 INFORMANT Mrs Mildred J. Stoner					
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke - Secondary to Massive Blood Loss DUE TO (b) Due - Perforation Stomach - Cancerous DUE TO (c) of Superior Mesenteric Artery + Location of Abdominal Aorta											
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.) Stabbed - butcher knife by wife during argument							
20c TIME OF INJURY Month Day, Year 7:30 p.m. 10-22-1967				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f (City or town) Mr. Boonsboro (County) Wash. (State) Md.			
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Edward W. Ditto, III				M.D.				22. DATE SIGNED 10-25-67			
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				217 W. Wash. St. Hagerstown, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial				23b DATE THEREOF 10/25/67		23c NAME OF CEMETERY OR CREMATORY Rode Hill Cemetery		23d LOCATION (City or Town) Hagerstown Wash Co Md (County) (State)			
24. FUNERAL DIRECTOR Hagerstown Md. Andrew K. Coffman Funeral Home Inc.						25b REG'D BY REG STRAR OCT 30 1967		25a REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14604

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 30 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle THEODORE Last STROUSE		4. DATE OF DEATH Month OCTOBER Day 22 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/1878
9. AGE (In years lost birthday) 89 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED AGENT	
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES R. STROUSE		14. MOTHER'S MAIDEN NAME MARY GLENTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 705-10-4785	
17. INFORMANT MRS. EDNA S. ANDREWS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO (b) Arteriosclerotic disease cerebral DUE TO (c) indif	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus; pneumonitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-24-64 , 19__ to 10-22-67 , 19__, that (I) (we) last saw the deceased alive on 10-21-67 , 19__, and that death occurred at 1:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Robert F. Keadle, M.D.		22b. DATE SIGNED 10-24-67	
22c. PHYSICIAN'S NAME (Type) Robert F. Keadle, M.D.		22d. ADDRESS Hagerstown, Md. 21740	
23a. BURIAL, CREMATION, REMAINS BURIAL		23b. DATE THEREOF 10/24/67	
23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.	
24. FUNERAL DIRECTOR W.J. Norment, Hagerstown, Md.		25a. REC'D BY REGISTRAR OCT 25 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

CERTIFICATE OF DEATH

14595

14605

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY in 1b 455 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL				d. STREET ADDRESS 637 Lincoln Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gladys Middle May Last SULLIVAN				4. DATE OF DEATH Month Oct. Day 26 , Year 1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1886	9. AGE (In years last birthday) 80 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Brant				14. MOTHER'S MAIDEN NAME Elmer Deahl Levin Deahl			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Earl R. Sullivan 637 Lincoln Street Cumberland, Md. 21502			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis, general DUE TO (c) unknown						INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (1) Diabetes Mellitus (2) Fracture of hip						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell when transferring to a couch (medical examiner notified by body person)					
20c. TIME OF INJURY Month, Day, Year Hour 11:00 p.m. 11/10/66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cumberland, Allegany, Md	
21. I certify that (I) (this hospital) attended the deceased from July 38, 1966 to Oct. 26, 1967 , that (I) (we) saw the deceased alive on October 26, 1967 , and that death occurred at 12:50 A M, from causes and on the date stated above							
22a. SIGNATURE Victor L. Ramos, M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED Oct. 26, 1967	
22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS, M.D.		22d. ADDRESS Western Md. State Hospital Hagerstown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-29-67		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.	
24. FUNERAL DIRECTOR H. Lee Silcox		ADDRESS 404 Decatur St. Cumb., Md.		25a. REC'D BY REGISTRAR OCT 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14606

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagers Town</u>		c. LENGTH OF STAY IN TB <u>21 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>RFD #2 Knoxville, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Martha Naomi Sullivan</u>		4. DATE OF DEATH Month <u>October</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 10, 1915</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE (in years last birthday) <u>52</u> yrs.
13. FATHER'S NAME <u>Albert Newton Deaner</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Weverton, Md.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
16. SOCIAL SECURITY NO. <u>214-32-2613</u>		17. INFORMANT <u>Paul A. Sullivan</u> <u>RFD #2, Knoxville, Md. 21758</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Heart Failure</u> DUE TO (b) <u>Pulmonary Vascular Hypertension</u> DUE TO (c) <u>Pulmonary Fibrosis, chronic bronchitis, emphysema</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>Years</u> <u>Years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 9, 1967</u> to <u>Oct 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 9, 1967</u> , and that death occurred at <u>4:15 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Charles C. Spencer</u>		22b. DATE SIGNED <u>10-10-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles C. Spencer</u>		22d. ADDRESS <u>145 S. Prospect Hagers Town</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brownsville Heights</u>	23d. LOCATION (City or Town) (County) (State) <u>Brownsville, Md.</u>
24. FUNERAL DIRECTOR <u>Ronald E. Eales</u>		25a. REC'D BY REGISTRAR <u>Harper's Ferry, West Va.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 13 1967</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (15)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14607

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 131 S PROSPECT ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last M JOSEPHINE SWEENEY		4. DATE OF DEATH Month Day Year OCTOBER 14 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/27/1887
9. AGE (in years last birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (State or foreign country) WASHINGTON COUNTY MD.		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME JOHN B SWEENEY		15. MOTHER'S MAIDEN NAME SOPHIA J HURLEY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		17. SOCIAL SECURITY NO.	
18. INFORMANT W. WARREN STULTZ		Address HAGERSTOWN MARYLAND	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to anoxia of brain following DUE TO (b) foreign body (piece of meat wedged in trachea.) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 34 hours			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Large piece of meat wedged in trachea.	
20c. TIME OF INJURY Month, Day, Year Hour 8 p.m. 10-12-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work Restaurant	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hagerstown, Washington, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E W DITTO JR.		22. DATE SIGNED 10/16/67	
EXAMINER'S NAME (Type) E W DITTO JR. M.D.		23. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/16/67	
23c. LOCATION (City, town or county) (State) HAGERSTOWN WASHINGTON MD.		23d. REC'D BY REGISTRAR Charles M Rouzer	
23e. REGISTRAR'S SIGNATURE Charles M Rouzer		23f. DATE OCT 19 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14593

14608

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>427 W. Franklin St.</u>		d. STREET ADDRESS <u>427 W. Franklin St.</u>	
3. NAME OF DECEASED (Type or print) <u>Barry Eugene Templon</u>		4. DATE OF DEATH <u>October 28 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5, 1967</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard M. Templon</u>		14. MOTHER'S MAIDEN NAME <u>Eva Jean Perrott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. R. M. Templon</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hydrocephalus and spina bifida</u> DUE TO (b) <u>1512</u> DUE TO (c) <u>12 wks.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 5</u> , 19 <u>67</u> , to <u>Oct. 28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept. 11</u> , 19 <u>67</u> , and that death occurred at <u>4A.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>B. B. Kneisley</u>		22b. DATE SIGNED <u>10/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>		22d. ADDRESS <u>148 West Washington St. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/29/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>
24. FUNERAL DIRECTOR <u>Wm. C. Hoff</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
Address <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT 31 1967</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67


14598

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 3 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		e. STREET ADDRESS Route 1	
3. NAME OF DECEASED (Type or print) HERMAN STANLEY TOMS		4. DATE OF DEATH Month October Day 27 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 29, 1890
9. AGE (n years lost birthday) 77 yrs		10. IF UNDER 1 YEAR Months 15 Days 4 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY shoe factory	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Sheridan Toms		14. MOTHER'S MAIDEN NAME Olivia Wolfe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 205-09-0560	
17. INFORMANT Mrs. Ruth Easterday, Boonsboro, Md.		Address Route 7	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOCLEROTIC HEART DISEASE DUE TO (c) 15 yrs.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from AUGUST 7, 1967 , to OCTOBER 27, 1967 , that (I) (we) last saw the deceased alive on OCTOBER 27, 1967 , and that death occurred at 4:45 P.M. from causes and on the date stated above.			
22a. SIGNATURE Dominico A. Garcia		22b. DATE SIGNED October 27, 1967	
22c. PHYSICIAN'S NAME (Type) DOMINICO A. GARCIA		22d. ADDRESS WESTERN MARYLAND STATE HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 10/29/67	23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Waynesboro, Pa.
24. FUNERAL DIRECTOR Gladhill Company, Middletown, Md.		25a. REC'D BY REGISTRAR OCT 30 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

14610

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARTHA VIRGINIA VIRTS		4. DATE OF DEATH Month Oct Day 22 Year 19 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 1, 1877
9. AGE (In years last birthday) 89		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Grim		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216-48-6548	
17. INFORMANT Charles F. Virts		Address Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Insufficiency DUE TO (b) Atherosclerotic Heart Disease DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 22 , 19 67 , to Oct 22 , 19 67 , that (I) (we) last saw the deceased alive on Oct 22 , 19 67 , and that death occurred at 2.55M , from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED Oct 24, 67	
22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.		22d. ADDRESS 100 Prof. Arts Bldg. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/25/67	23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery	23d. LOCATION (City or Town) (County) (State) Knoxville Maryland
24. FUNERAL DIRECTOR Laurel Funeral Home		25a. REC'D BY REG. STAFF Charles Judge	
ADDRESS Brunswick, Md.		DATE OCT 26 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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CERTIFICATE OF DEATH

14611

14601

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institut on. Residence before admission) a. STATE Maryland b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN TB 747 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		d. STREET ADDRESS Route 1	
3. NAME OF DECEASED (Type or print) Iva Susan Weddle		4. DATE OF DEATH Month Oct. Day 24 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1892
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State or foreign country) Frederick County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Hewitt		14. MOTHER'S MAIDEN NAME Susan Sheets	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 212-38-9717	
17. INFORMANT Glenn Weddle		Address Frederick, Md. RD 7	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) lobular pneumonia DUE TO (b) cerebral thrombosis & hemiplegia raphana DUE TO (c) arteriosclerosis, general			INTERVAL BETWEEN ONSET AND DEATH 4 days 2 years unknown
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. pm 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from Oct. 7, 1965 to Oct. 24, 1967 , that (1) (no) saw the deceased alive on Oct. 24, 1967 , and that death occurred at 7:25 M, from causes and on the date stated above			
22a. SIGNATURE Victor L. Ramos, M.D.		22b. DATE SIGNED Oct. 24, 1967	
22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS, M.D.		22d. ADDRESS Western Md. State Hospital Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-28-67	23c. NAME OF CEMETERY OR CREMATORY Lowistown Cemetery	23d. LOCATION (City or Town) (County) (State) Lowistown Fred. Co. Md
24. FUNERAL DIRECTOR Raymond E. Creager		25a. REC'D BY REGISTRAR Oct 30 1967	
ADDRESS Thurmont, Md.		25b. REGISTRAR'S SIGNATURE Charles J. J...	

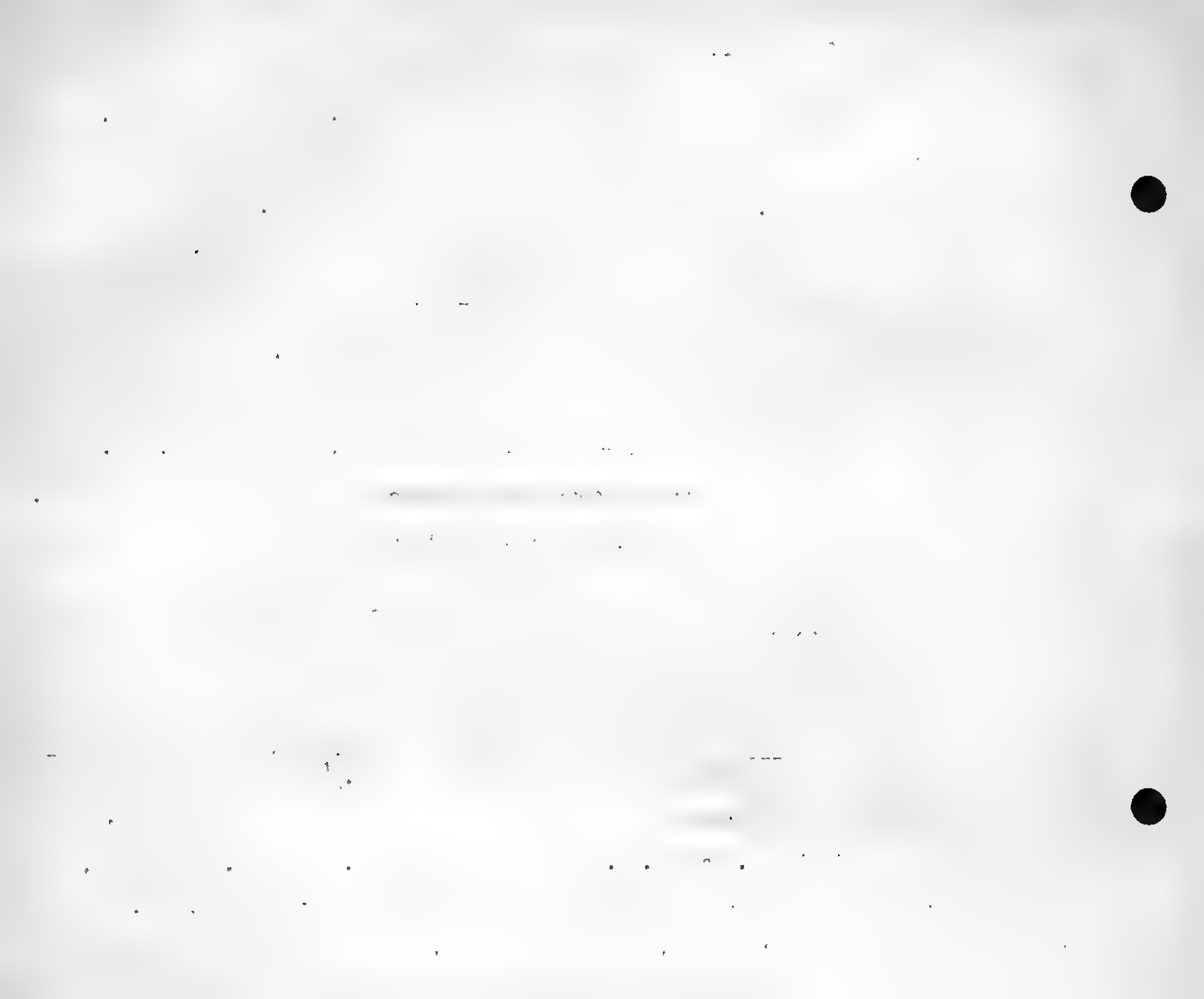
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and 4. These should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14602
CERTIFICATE OF DEATH
14612

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 61 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1336 Salem Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1336 Salem Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Jacob Last Weddle		4. DATE OF DEATH Month October Day 24 , Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-13-88
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) conductor		10b. KIND OF BUSINESS OR INDUSTRY railroad	
11. BIRTHPLACE (County & State, or foreign country) Edgemont, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Daniel Weddle		14. MOTHER'S MAIDEN NAME Jennie Wolfe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-10-7766	
17. INFORMANT Leroy Weddle, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Atherosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Podagra		INTERVAL BETWEEN ONSET AND DEATH 5 mins. Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 23 , 19 67 , to Oct 24 , 19 67 , that (I) (we) last saw the deceased alive on Oct 23 , 19 67 , and that death occurred at 7:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE W. T. Layman		22b. DATE SIGNED Oct 25, 1967	
22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.		22d. ADDRESS 100 Prof. Arts Bldg. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-27-67	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR OCT 30 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14603

14613

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Penna. b COUNTY Franklin	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c LENGTH OF STAY IN 1b 2 wks	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital		d STREET ADDRESS 231 W. North St.	
3. NAME OF DECEASED (Type or print) Charles Clinton Wetzel		4 DATE OF DEATH Month 10- Day 13- Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 25, 1894
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier		10b KIND OF BUSINESS OR INDUSTRY U.S. Post Office	
11 BIRTHPLACE (County & State, or foreign country) Franklin Co., Penna.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME William O. Wetzel		14. MOTHER'S MAIDEN NAME Mary Alice Gossard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 207-30-5455	
17. INFORMANT Mrs. Charles C. Wetzel Sr.		Address Waynesboro, Pa.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to asphyxia and fever alien DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic obstructive + chronic bronchitis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic heart disease		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that death occurred on _____ M, from causes on and on the date stated above.			
22a SIGNATURE Eunice S. Sauer		22b. DATE SIGNED	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL, (Specify) Burial		23b DATE THEREOF 10/16/1967	
23c NAME OF CEMETERY OR CREMATORY Burns Hill		23d LOCATION (City or Town) (County) (State) Waynesboro, Franklin, Pa.	
24 FUNERAL DIRECTOR Walter G. Goss		25a REC'D BY REGISTRAR OCT 19 1967	
ADDRESS Waynesboro, Penna.		25b REGISTRAR'S SIGNATURE Richard J. Goss	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 1/2 Hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS 19 West Washington St	
3 NAME OF DECEASED (Type or print) First BESSIE Middle VIOLA Last WIDMYER		4 DATE OF DEATH Month Oct Day 12 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 3 1889
9 AGE (In years lost birthday) 77 yrs		10 IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min 77	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		11b. KIND OF BUSINESS OR INDUSTRY Retired	
12 BIRTHPLACE (County & State, or foreign country) Clear Spring Wash Co. Md.		13 CITIZEN OF WHAT COUNTRY? USA	
14 FATHER'S NAME Jerry Trumppower		15 MOTHER'S MAIDEN NAME Jennie Kinsell	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		17 SOCIAL SECURITY NO 214-09-8863	
18 INFORMANT Mrs Helen Earley		19 ADDRESS 54 No Cannon Ave Hagerstown Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Arteriosclerotic Heart Disease DUE TO (c) Several years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 11, 1967 , to Oct. 12, 1967 , that (I) (we) last saw the deceased alive on Oct. 11, 1967 , and that death occurred at 2 A.M. from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 10-13-67	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/14/67	23c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery	23d. LOCATION (City or Town) (County) (State) Clear Spring Wash Co Md
24 FUNERAL DIRECTOR Andrew K. Cogfman Funeral Home Inc		25a. REC'D BY REGISTRAR OCT 16 1967	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14605

CERTIFICATE OF DEATH

14615

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN RT.#5			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WATER ST. LEITERSBURG				d. STREET ADDRESS WATER ST. LEITERSBURG		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELVA MAY WILHIDE				4. DATE OF DEATH Month Day Year OCTOBER 13 19 67			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JUNE 10 1888		9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN H. HOVIS				14. MOTHER'S MAIDEN NAME ANNIE HURD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 177-24-7214		17. INFORMANT MR. WALTER F. BARNHART		Address RT#5 HAGERSTOWN MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Occlusion DUE TO Arteriosclerotic Cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 yrs. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-6, 1958 , to 10-13, 1967 , that (I) (we) last saw the deceased alive on 10-2, 1967 , and that death occurred at 6:00 A.M. , from causes and on the date stated above.							
22a. SIGNATURE Charles F. Hess				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-16-67	
22c. PHYSICIAN'S NAME (Type) CHARLES F. HESS M.D.				22d. ADDRESS SMITHSBURG, MD.			
23a. BURIAL, CREMATION, REMAINS (Specify) BURIAL		23b. DATE THEREOF 10/16/67		23c. NAME OF CEMETERY OR CREMATORY LEITERSBURG LUTHERN		23d. LOCATION (City or Town) (County) (State) WASHINGTON CO. MD.	
24. FUNERAL DIRECTOR W. J. Hornum Hagerstown, Md.				25a. REC'D BY REGISTRAR OCT 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14605

CERTIFICATE OF DEATH

14616

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 2 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HANCOCK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL			d. STREET ADDRESS RFD #2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last HERMAN ELWOOD YOUNKER			4. DATE OF DEATH Month Day Year OCTOBER 31 1967		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/31/1913		9. AGE (In years lost birthday) yrs. 54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO., MD.	
13. FATHER'S NAME HARRY CLEATUS YOUNKER			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO.		
17. INFORMANT RANSY M. YOUNKER RFD #2, HANCOCK, MD.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 10 adenocarcinoma of stomach with disseminated metastasis DUE TO metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 13 mos.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 9-3-66 , 19__ to 10-31-67 , 19__, that (I) (we) last saw the deceased alive on 10-31-67 , 19__, and that death occurred at 8:05 PM , from causes and on the date stated above.					
22a. SIGNATURE <i>John H. Kehne</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-2-67
22c. PHYSICIAN'S NAME (Type) John H. Kehne, M.D.			22d. ADDRESS 1229 Ravenwood Heights, Hagerstown, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/3/1967		23c. NAME OF CEMETERY OR CREMATORY PARKHEAD E.U.B.	
23d. LOCATION (City or Town) (County) (State) WASHINGTON COUNTY, MD.					
24. FUNERAL DIRECTOR HOWARD J GROVE			ADDRESS HANCOCK, MARYLAND		
25a. REC'D BY REGISTRAR NOV 6 1967			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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WASHINGTON

ROAD STONE

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RURAL HARBOR

WASHINGTON

WASHINGTON COUNTY HOSPITAL

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HOSPITAL

HARRY OF EATON YOUNGER

JOHN LOUIS MOORE

HARRY J. YOUNGER REG. N. HARBOR, MD.

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JOHN H. KIRBY, M.D.

STREET 11333 PARKWAY E.U.D.

STREET 11333 PARKWAY E.U.D.

WASHINGTON COUNTY, MD.